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Workers' Compensation Regulations, January 1, 2011 - Edition

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Article 1. General

New query

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§1. Definitions.

As used in the regulations in Chapter 1:

(a) "Accreditation" means the conferring of recognized status as a provider of physician education by the Administrative Director.

(b) "ACOEM" shall have the same meaning as section 9792.20(a), and "ACOEM Practice Guidelines" shall have the same meaning as section 9792.20(b) of Title 8 of the California Code of Regulations.

(c) "Administrative Director" means the administrative director of the Division of Workers' Compensation of the State of California Department of Industrial Relations, and includes his or her designee.

(d) "Agreed Panel QME" means the Qualified Medical Evaluator described in Labor Code section 4062.2(c), that the claims administrator, or if none the employer, and a represented employee agree upon and select from a QME panel list issued by the Medical Director without using the striking process. An Agreed Panel QME shall be entitled to be paid at the same rate as an Agreed Medical Evaluator under section 9795 of Title 8 of the California Code of Regulations for medical/legal evaluation procedures and medical testimony.

(e) "AMA Guides" means American Medical Association, Guides to the Evaluation of Permanent Impairment [Fifth Edition].

(f) "AME" means Agreed Medical Evaluator, a physician selected by agreement between the claims administrator, or if none the employer, and a represented employee to resolve disputed medical issues referred by the parties in a workers' compensation proceeding.

(g) "Appeals Board" means the Workers' Compensation Appeals Board within the State of California Department of Industrial Relations.

(h) "Audit" means a formal evaluation of a continuing education program, disability evaluation report writing course, or an accredited education provider which is conducted at the request of the Medical Director.

(i) "Comprehensive Medical-Legal Evaluation" means a medical evaluation performed pursuant to Labor Code Sections 4060, 4061, 4062, 4062.1, 4062.2 or 4067 and meeting the requirements of section 9793(c) of Title 8 of the California Code of Regulations.

(j) "Claims Administrator" means the person or entity responsible for the payment of compensation for any of the following: a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, a group self-insurer, an insured employer, the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF) and for the Subsequent Injuries Benefit Trust Fund (SIBTF), a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, group self-insurer, or joint powers authority, and the California Insurance Guarantee Association (CIGA). The UEBTF shall only be subject to these regulations after proper service has been made on the uninsured employer and the Appeals Board has obtained jurisdiction over the UEBTF by joinder as a party.

(k) "Continuing Education Program" means a systematic learning experience (such as a course, seminar, or audiovisual or computer learning program) which serves to develop, maintain, or increase the knowledge, skills and professional performance of physicians who serve as Qualified Medical Evaluators in the California workers' compensation system.

(l) "Course" means the 12 hours of instruction in disability evaluation report writing which is required of a Qualified Medical Evaluator prior to appointment. A course must be approved by the Administrative Director.

(m) "Credit Hour" means a sixty minute hour. A credit hour may include time for questions and answers related to the presentation.

(n) "Direct medical treatment" means that special phase of the physician-patient relationship during which the physician: (1) attempts to clinically diagnose and to alter or modify the expression of a non-industrial illness, injury or pathological condition; or (2) attempts to cure or relieve the effects of an industrial injury.

(o) "Distance Learning" means an education program in which the instructor and student are in different locations, as in programs based on audio or video tapes, computer programs, or printed educational material.

(p) "DEU" is the Disability Evaluation Unit under the Administrative Director responsible for issuing summary disability ratings.

(q) "Education Provider" means the individual or organization which has been accredited by the Administrative Director to offer physician education programs. There are two categories of providers: (1) the Administrative Director; and (2) individuals, partnerships, or corporations, hospitals, clinics or other patient care facilities, educational institutions, medical or health-related organizations whose membership includes physicians as defined in Labor Code section 3209.3, organizations of non-medical participants in the California workers' compensation system, and governmental agencies. In the case of a national organization seeking accreditation, the California Chapter or organization affiliated with the national organization shall be accredited by the Administrative Director in lieu of the national organization.
(r) "Employer" means any employer within the meaning of Labor Code section 3300, including but not limited to, any of the following: (1) an uninsured employer and the Uninsured Employers Benefits Trust Fund (UEBTF) pursuant to Labor Code Section 3716, (2) an insured employer, (3) a self-insured employer and (4) a lawfully uninsured employer. The UEBTF shall only be subject to these regulations after proper service has been made on the uninsured employer and the Appeals Board has obtained jurisdiction over the UEBTF by joinder as a party.

(s) "Evaluator" means any of the following: "Qualified Medical Evaluator", "Agreed Medical Evaluator", "Agreed Panel QME" or "Panel QME", as appropriate in a specific case.

(t) "Follow-up comprehensive medical-legal evaluation" means a medical evaluation performed pursuant to Labor Code sections 4060, 4061, 4062, 4062.1, 4062.2 or 4067 and meeting the requirements of Section 9793(f) of Title 8 of the California Code of Regulations.

(u) "Medical Treatment Utilization Schedule" or "MTUS" means the treatment utilization scheduled adopted by the Administrative Director of the Division of Workers' Compensation as required by Labor Code section 5307.27 and sections 9792.20 et seqof Title 8 of the California Code of Regulations.

(v) "Medical Director" means the Medical Director appointed by the Administrative Director pursuant to Labor Code section 122 and includes any Associate Medical Directors when acting as his or her designee.

(w) "Mental health record" means a medical treatment or evaluation record created or reviewed by a licensed physician as defined in Labor Code section 3209.3 in the course of treating or evaluating a mental disorder.

(x) "Panel QME" means the physician, from a QME panel list provided by the Medical Director, who is selected under Labor Code section 4062.1(c) when the injured worker is not represented by an attorney, and when the injured worker is represented by an attorney, the physician whose name remains after completion of the striking process or who is otherwise selected as provided in Labor Code section 4062.2(c) when the parties are unable to agree on an Agreed Panel QME.

(y) "Physician's office" means a bona fide office facility which is identified by a street address and any other more specific designation such as a suite or room number and which contains the usual and customary equipment for the evaluation and treatment appropriate to the physician's medical specialty or practice.

(z) "Qualified Medical Evaluator (QME)" means a physician licensed by the appropriate licensing body for the state of California and appointed by the Administrative Director pursuant to Labor Code section 139.2, provided however, that acupuncturist QMEs shall not perform comprehensive medical-legal evaluations to determine disability.

(aa) "QME competency examination" means an examination administered by the Administrative Director for the purpose of demonstrating competence in evaluating medical-legal issues in the workers' compensation system. This examination shall be given at least as often as twice annually.

(bb) "QME competency examination for acupuncturists" means an examination administered by the Administrative Director for the purpose of demonstrating competence in evaluating medical-legal issues in the workers' compensation system which are not pertinent to the determination of disability, but should be understood by acupuncturist QMEs. This examination shall be given at least as often as twice annually.

(cc) "Significant Financial Interest or Affiliation Held by Faculty", as used in sections 11.5, 14, 55, 118 and 119 pertaining to faculty of approved disability report writing or continuing education courses under these regulations, means grant or research support; status as a consultant, member of a speakers' bureau, or major stock shareholder; or other financial or material interest for the program faculty member or his or her family.

(dd) "Specified Financial Interests" means having a shared financial interest that must be reported or disclosed pursuant to sections 11, 17, 29, 50 or on the "SFI Form 124" attached to QME Form 100, 103 or 104 as required by these regulations.

(ee) "Supplemental medical-legal evaluation" means a medical evaluation performed pursuant to Labor Code sections 4060, 4061, 4062, 4062.1, 4062.2 or 4067 and meeting the requirements of section 9793(l) of Title 8 of the California Code of Regulations.

(ff) "Treating physician" means a physician who has provided direct medical treatment to an employee which is reasonably required to cure or relieve the effects of an industrial injury pursuant to section 4600 of the Labor Code.

(gg) "Unrepresented employee" means an employee not represented by an attorney.

Note: Authority cited: Sections 53, 133, 139.2, 4060, 4061, 4062, 4062.1, 4062.2 and 5307.3, Labor Code. Reference: Sections 139.2, 139.3, 139.31, 139.4, 139.43, 3716, 4060, 4061, 4061.5, 4062, 4062.1, 4062.2, 4062.3, 4062.5, 4067, 4600, 4604.5 and 4660-4664, Labor Code.

HISTORY

1. Repealer and new section filed 8-1-94; operative 8-31-
94 (Register 94, No. 31). For prior history, see Register 93, No. 38.

2. Change without regulatory effect amending subsections (c), (g), (h), (k) and (p) filed 9-19-94 pursuant to section 100, title 1, California Code ofRegulations (Register 94, No. 38).

3. Amendment of subsections (d) and (f), repealer and new subsection (m),
amendment of subsections (n) and (o), new subsections (p) and (q) and
subsection relettering, and amendment of newly designated subsection (r) filed 8-23-96; operative 9-22-
96 (Register 96, No. 34).

4. New subsection (s) and subsection relettering filed 6-3-97; operative 7-3-97 (Register 97, No. 23).

5. Amendment of subsections (f) and (r) filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

6. New subsections (a) and (e), repealer of former subsection (f), new
subsections (h), (j), (k), (m), (r) and (x) and subsection relettering filed 10-16-2000 as an emergency; operative 1-1-2001 (Register 2000, No. 42). A Certificate of Compliance must be transmitted to OAL by 5-1-2001 or emergency language will be repealed by operation of law on the following day.

7. New subsections (a) and (e), repealer of former subsection (f), new
subsections (h), (j), (k), (r) and (x) and subsection relettering refiled 5-2- 2001 as an emergency; operative 5-2-2001 (Register 2001, No. 18). A Certificate of Compliance must be transmitted to OAL by 8-30-2001 or emergency language will be repealed by operation of law on the following day.

8. Certificate of Compliance as to 5-2-2001 order, including further amendment of section, transmitted to OAL 7-12-2001 and filed 8-23-2001 (Register 2001, No. 34).

9. Amendment of chapter heading, section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 2. QME Eligibility
New query

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§10. Appointment of QMEs.

(a) Applications for appointment as a QME shall be submitted on the form in section 100 (QME Form 100). The completed application form, and any supporting documentation as required by the application, shall be filed at the Administrative Director's office listed on the form in section 100. Upon his or her approval of each application form and supporting documentation, the Administrative Director shall certify, as eligible to sit for the QME competency examination, those applicants who meet all of the statutory and regulatory eligibility requirements. Any application for appointment may be rejected if it is incomplete, contains false information or does not contain the required supporting documentation listed in section 11.

(b) The Administrative Director may deny appointment or reappointment to any physician who has performed a QME evaluation or examination without valid QME certification at the time of examining the injured worker or the time of signing the initial or follow-up evaluation report. An applicant serving a period of probation imposed by the applicant's professional licensing board or agency may be allowed to take the QME examination while on probationary license status. Applications for appointment or reappointment from physicians who are on probationary license status with a California licensing board or agency while the QME application is pending shall be reviewed by the Medical Director on a case-by-case basis consistent with the provisions of Labor Code section 139.2(m).

(c) No physician who has been convicted of a felony or misdemeanor related to his or her practice shall be appointed or reappointed as a QME. An applicant who has been convicted of any other type of felony or misdemeanor may be denied appointment or reappointment.

(d) Any physician who, while under investigation or after the service of a statement of issues or accusation for alleged violations of these regulations or the Labor Code, withdraws his or her application for appointment or reappointment, resigns or fails to seek reappointment as a QME, shall be subject to having the disciplinary process reactivated whenever an application for appointment or re-appointment is subsequently filed. In the event any of the alleged violations are found to have occurred, the physician's application for appointment or reappointment may be denied by the Administrative Director.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code; and Section 730, Business and Professions Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1 and 4062.2, Labor Code; and Section 730, Business and

Professions Code.

HISTORY

1. Relocation of article 2 heading and new section filed 8-1-94; operative 8- 31-94 (Register 94, No. 31).

2. Amendment of section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

3. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

4. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§ 10.1. The Application for Appointment as Qualified Medical Evaluator Form. [Repealed]

NOTE

Authority cited: Sections 133, 139 and 139.2, Labor Code. Reference: Sections 139.2, 4060, 4061 and 4062, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Change without regulatory effect updating QME Application Form filed 6-27-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 26).

3. Change without regulatory effect amending specialty codes filed 10-11-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 41).

4. Change without regulatory effect amending QME Application form and adding MAP specialty code filed 12-27-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 52).

5. Change without regulatory effect amending MD/DO specialty codes filed 6-19-97 pursuant to section 100, title 1, California Code of Regulations (Register 97, No. 25).

6. Change without regulatory effect amending MD/DO speciality codes and updating form revision date filed 4-15-98 pursuant to section 100, title 1, California Code of Regulations (Register 98, No. 16).

7. Change without regulatory effect amending QME appointment application form filed 8-19-98 pursuant to section 100, title 1, California Code of Regulations (Register 98, No. 34).

8. Change without regulatory effect amending MD/DO specialty codes and updating form revision date filed 7-12-99 pursuant to section 100, title 1, California Code of Regulations (Register 99, No. 29).

9. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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New query

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§10.1A. Reappointment Application as Qualified Medical Evaluator Form. [Repealed]

HISTORY

1. Change without regulatory effect adding new section filed 6-20-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 25).

2. Change without regulatory effect repealing section and adding new section filed 4-16-98 pursuant to section 100, title 1, California Code of Regulations (Register 98, No. 16).

3. Change without regulatory effect amending block 2, item 3 and verification statement in block 5 filed 8-12-98 pursuant to section 100, title 1, California Code of Regulations (Register 98, No. 33).

4. Change without regulatory effect amending block 5 filed 10-30-98 pursuant to section 100, title 1, California Code of Regulations (Register 98, No. 44).

5. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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Article 2. QME Eligibility
New query

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§10.2. The QME Fee Assessment Notice Form.

QME Fee Assessment Form (Sample) (.pdf format, 26K)

NOTE

Authority cited: Sections 133, 139 and 139.2, Labor Code. Reference: Sections 139.2, 4060, 4061 and 4062, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Repealer and new section filed 6-7-99 as an emergency; operative 6-7-99 (Register 99, No. 24). A Certificate of Compliance must be transmitted to OAL by 10-5-99 or emergency language will be repealed by operation of law on the following day.

3. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 3).

4. New section filed 1-19-2000; operative 1-19-2000 pursuant to Government Code section 11343.4(d) (Register 2000, No. 3).

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§\10.5. [Reserved]

Note: Authority cited: Sections 139 and 139.2. Reference: 8 U.S.C. Sections 1621, 1641 and 1642; Sections 139.2, 5307.3 and 5307.4, Labor Code; and Section 11507 et seq., Government Code.

HISTORY

1. New section filed 11-5-98; operative 12-5-98 (Register 98, No. 45).

2. Change without regulatory effect repealing and adding new Form 10.5, Rev. 5/99 (incorporated by reference) filed 7-12-99 pursuant to section 100,title 1, California Code of Regulations (Register 99, No. 29).

3. Amendment of subsections (e)(1), (e)(3) and (i) and repealer of subsections (i)(1)-(6) filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

4. Repealer filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§11. Eligibility Requirements for Initial Appointment as a QME.

The Administrative Director shall appoint as QMEs all applicants who meet the requirements set forth in Labor Code Section 139.2(b) and all applicants:

(a) Shall submit the required supporting documentation:

(1) Copy of current license to practice in California;

(2) For Medical Doctors, or Doctors of Osteopathy:

(A) A copy of the applicant's certificate of completion of postgraduate specialty training at an institution recognized by the Accreditation Council for Graduate Medical Education or the osteopathic equivalent as defined pursuant to Section 12, or;

(B) A copy of the applicant's Board certification by a specialty board recognized by the Administrative Director or as defined pursuant to Section 12, or;

(C) A declaration under penalty of perjury accompanied by supporting documentation that the physician has qualifications that the Administrative Director and the Medical Board of California or the Osteopathic Medical Board of California both deem to be equivalent to board certification in a specialty.

(3) If a psychologist, (i) a copy of 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, and has not had less than five years postdoctoral experience in the treatment of emotional and mental disorders or (ii) served as an AME on eight or more occasions prior to January 1, 1990 and has not less than five years postdoctoral experience in the diagnosis and treatment of emotional and mental disorders.

(4) For Doctors of Chiropractic, the physician shall provide (1) a copy of a current or otherwise valid certificate in

California Workers Compensation Evaluation by either a California professional chiropractic association or an accredited California college recognized by the Administrative Director (i.e. Workers' Compensation Evaluation Certificate with a minimum 44 hours completed) or; (2) a certificate of completion of a chiropractic postgraduate specialty program of at least 300 hours taught by a school or college recognized by the Administrative Director, the Board of Chiropractic Examiners and the Council on Chiropractic Education.

(5) Or, for other physicians, a copy of the physician's professional diploma.

(b)(1) Shall, prior to appointment as a QME, complete a course of at least twelve (12) hours in disability evaluation report writing pursuant to section 11.5 of this Article. Doctors of Chiropractic who submit documentation showing compliance with section 11(a)(4)(1) are exempt from this requirement; and

(2) Shall accurately and fully report on the SFI Form 124 attached to the application (QME Form 100) to the best of the applicant's knowledge the information required by section 29 of Title 8 of the California Code of Regulations, regarding applicant's specified financial interests.

(c) Shall provide supplemental information and/or documentation to the Administrative Director after an application, QME Form 100 (see, 8 Cal. Code Regs. § 100), is submitted if requested to verify an applicant's eligibility for appointment.

(d) Shall agree that during a QME evaluation exam he or she will not treat or offer or solicit to provide medical treatment for that injury for which he or she has done a QME evaluation for an injured worker unless a medical emergency arises as defined under subdivision (a) or (b) of section 1317.1 of the Health and Safety Code. A QME may also provide treatment if requested by the employee pursuant to section 4600 of the Labor Code, but he or she shall not offer or solicit to provide it. A QME who solicits an injured worker to receive direct medical treatment or to become the primary treating physician of that employee shall be subject to disciplinary action pursuant to section 60.

(e) Shall declare under penalty of perjury on the QME application that he or she:

(1) Has an unrestricted California license and is not currently on probation from the state licensing board, or, if the applicant has a California restricted license or is currently on probation, state all the restrictions on the license and all terms of probation; and

(2) Devotes at least one-third of his or her total practice time to providing direct medical treatment during each year of the applicant's term of appointment. This requirement shall not apply if the applicant qualifies for appointment because the applicant served as an AME on 8 or more occasions in the year prior to application and in each year of the applicant's term; or if the applicant meets the requirements of section 15; and

(3) Has not performed a QME evaluation without QME certification;

(4) Has accurately and fully reported on QME Form 124 to the best of the applicant's knowledge the specified financial interest information required by section 29 of Title 8 of the California Code of Regulations.

(f) Shall pass the QME Competency Examination, or if an acupuncturist, shall pass the QME Competency Examination for acupuncturists.

(1) In order to take this examination, a physician who is not currently appointed as a QME and not exempt

pursuant to Labor Code section 139(b)(1), shall be considered to have applied to take the QME competency examination upon submitting the properly-completed Application for Appointment Form in Section 100 (see, 8 Cal. Code Regs. section 100), and the Registration Form for the QME Competency Examination in section 102 (see, 8 Cal. Code Regs. § 102) and the appropriate fee as specified in section 11(f)(2).

(2) The fee for applying to take or retake the QME competency examination is $ 125.00 and may be waived by the Administrative Director at his or her discretion for first time applicants.

(3) The Administrative Director shall give appropriate public notice of the date, time and location of the examination no fewer than sixty (60) calendar days before a competency examination is to be given.

(4) An applicant must submit the properly completed forms as required in section 11(f)(1) to the Administrative Director at least thirty (30) calendar days prior to the date of the next scheduled competency examination unless the Administrative Director finds good cause to grant an extension to the physician(s).

(5) The Administrative Director shall inform the applicant in writing whether he or she shall be allowed to take the examination within fifteen (15) calendar days from the date the Administrative Director receives the properly-completed forms and appropriate fee.

(6) The Administrative Director shall inform the applicant in writing whether or not he or she passed the examination within sixty (60) calendar days from the date the applicant takes the competency examination.

(7) An applicant who passes the QME competency examination shall file the QME Fee Assessment Form in Section 103 (see, 8 Cal. Code Regs. section 103) including the appropriate fee within thirty (30) days of the date of the notice. The physician shall not be appointed to the official QME list until the appropriate fee is paid and has completed a disability evaluation report writing course pursuant to section 11.5. Appointments shall be for two-year terms beginning with the date of appointment by the Administrative Director.

(8) Any applicant, who upon good cause shown by the test administrator, is suspected of cheating may be disqualified from the examination and, upon a finding that the applicant did cheat in that exam, the applicant will be denied further admittance to any QME examination for a period of at least five years thereafter. Any applicant who fails to follow test instructions and/or proctor instructions either before or during or at the conclusion of an examination shall be disqualified from the examination procedure and the applicant's exam shall be nullified.

(9) If an applicant fails the competency examination or fails to appear for a noticed QME examination for which the applicant has submitted a QME Exam Registration Form 102 (see, 8 Cal. Code Regs. § 102), the applicant may apply to take any subsequent examinations, upon submission of a new test application form and a fee of $125. An applicant who fails the exam three times shall show proof of having completed six (6) hours continuing education from a course approved by the Administrative Director prior to taking the examination again.

(10) Any applicant who receives a failing grade on a competency exam may appeal the failing grade to the Administrative Director. Appeals shall be considered on a case by case basis. Appeals will be accepted immediately after a candidate has completed the examination and until ten (10) days after the date of the examination results letter. The appeal shall state specific facts as to why the failing grade should be overturned. Pursuant to Section 6254(g) of the Government Code, the Administrative Director will consider appeals of test questions and will base his or her decision solely on the written appeal including any supporting documentation submitted by the physician.

Appeals will only be accepted for the current examination period. Grounds for appeal are:

(A) Significant procedural error in the examination process;

(B) Unfair Discrimination;

(C) Bias or fraud.

(g) Each applicant shall pay the annual fee required by section 17 of this Article prior to appointment.

NOTE: Forms referred to above are available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Section 139.2, Labor Code; and Section 6254, Government Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. New subsections (a)-(c) and subsection relettering, amendment of newly designated subsections (d)-(f)(6), new subsections (f)(7) and (f)(8) and subsection renumbering, amendment of newly designated subsections (f)(9) and (f)(10), and new subsection (g) filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

3. Change without regulatory effect amending section (f)(5) filed 6-20-97 pursuant to section 100, title 1, California Code of Regulations (Register 97, No. 25).

4. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

5. Amendment of section heading and section filed 8-23-2001; operative 8-23-2001 pursuant to Government Code section 11343.4 (Register 2001, No. 34).

6. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§11.1. Application for QME Competency Examination Form. (Repealed)

NOTE

Authority cited: Section 139.2, Labor Code. Reference: Section 139.2, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Change without regulatory effect amending form filed 3-11-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 11).

3. Change without regulatory effect amending form filed 7-23-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 30).

4. Amendment of form filed 3-15-99; operative 4-14-99 (Register 99, No. 12).

5. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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New query

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§11.5. Disability Evaluation Report Writing Course

Prior to appointment as a QME, a physician shall complete a course of at least twelve hours of instruction in disability evaluation report writing. The course curriculum shall be specified by the Administrative Director. Only report writing courses which are offered by education providers as defined in subdivision 1(q) of Title 8 of the California Code of Regulations shall qualify to satisfy this requirement.

(a) An education provider applicant shall submit:

(1) a completed QME Form 118 (Application for Accreditation) (see, 8 Cal. Code Regs. § 118) which contains:

(A) the applicant's name; address; director of education with contact information; type of organization; length of time in business; nature of business; and past experience providing continuing education courses (including a list of other accrediting agencies that have approved such courses);

(B) a description of the proposed education program or course which includes the title; type (continuing education program or disability evaluation report writing course); location(s); date(s); length of training in clock hours; educational objectives; a complete description of the program or course content; faculty; and the names of other accrediting agencies that have approved the program.

(2) A curriculum vitae for each proposed instructor. A proposed instructor shall have education and/or training and recent work experience relevant to the subject of his/her presentation.

(3) The application for accreditation as an education provider, along with all required supporting documents, shall be submitted to the Administrative Director, at least 60 calendar days before any public advertisement of the applicant's course.

(b) The Administrative Director shall accredit an applicant that: meets the definition of an education provider; submits a completed, signed and dated application which demonstrates past experience in providing continuing education programs; and proposes a program which meets the requirements of section 55(c) or a course which meets the requirements of section 11.5(a) and (i). The applicant must demonstrate that adequate time is allocated to the

curriculum set forth in section 11.5(i) for the course to be approved by the Administrative Director. Proposed content for continuing education program credit must relate directly to disability evaluation or California workers' compensation-related medical dispute evaluation. No credit shall be recognized by the Administrative Director for material primarily discussing the business aspects of workers' compensation medical practice, including but not limited to billing, coding and marketing.

(c) The Administrative Director shall notify the applicant within 20 calendar days after receipt of the application containing all the information listed in section 11.5(a) whether that education provider has been accredited for a two year period and the proposed course has been approved. Incomplete applications will be returned to the applicant.

(d) Each education provider that has been accredited by the Administrative Director will be given a number which must be displayed on course promotional material.

(e) On or before the date the course is first presented, the education provider shall submit the program syllabus (all program handouts) to the Administrative Director.

(f) An approved course may be offered for two (2) years. An accredited education provider shall notify the Administrative Director in writing of any change to the faculty in an approved course. The provider shall send the Administrative Director the program outline, promotional material and faculty for each offering of the program at least 45 days prior to the date of the presentation of the program. The Administrative Director may require submission of the program syllabi. The Administrative Director may require changes in the program based on its review of the program outline, program syllabi, promotional material or faculty if the Administrative Director finds that any aspect of the program is not in compliance with these regulations.

(g) To apply for re-accreditation, the education provider applicant must submit a completed QME Form 118 (Application for Accreditation) (see, 8 Cal. Code Regs. § 118), using the application process in 11.5(a). The applicant may complete section 2 of the form using a new program or course or one which was given by the applicant during the recent accreditation period. The Administrative Director shall give the provider 90 days' notice of the need to seek re-accreditation.

(h) Promotional materials for a course must state the education provider's educational objectives; the professional qualifications of course faculty (at the least, all relevant professional degrees); the content of course activities; and the intended audience.

(i) The minimum of 12 hours of instruction in disability evaluation report writing shall include:

(1) The Qualified Medical Evaluator's Role in the Disability Evaluation Process (minimum recommended 1 hour)

How disability evaluation reports are used

The reasons why reports must be clear, complete and timely

The QME's role as an expert witness

Impact of the QME's report on the injured worker

QME ethics and the Confidentiality of Medical Information Act

(2) Elements of the Medical-Legal Report (minimum recommended 1 hour)

The Labor Code and regulatory requirements for medical-legal reports

(3) The Language of Reports (minimum recommended 4 hours)

Evaluation of disability in California (impairment and disability)

The occupational history

The physician examination and the role of testing

The Medical Treatment Utilization Schedule (MTUS) adopted by the Administrative Director pursuant to Labor Code section 5307.27, found in section 9792.20 et seqof Title 8 of the California Code of Regulations, and relevant portions of the ACOEM Practice Guidelines

Providing opinions that resolve disputed medical treatment issues consistent with the evaluation criteria specified in section 35.5 (d) of Title 8 of the California Code of Regulations

Packard Thurber's Evaluation of Industrial Disability, section 43 through 47 and section 9725 through 9727 of Title 8 of the California Code of Regulations (for cases with dates of injury not subject to the AMA guide-based impairment rating system, described below)

Factors of disability, including subjective and objective factors, loss of pre-injury capacity and work restrictions, for cases involving dates of injury not subject to the AMA guide-based impairment rating system

Activities of Daily Living, for cases subject to the AMA Guides

Work restrictions

Work Capabilities

American Medical Association, Guides to the Evaluation of Permanent Impairment, [Fifth Edition] (AMA Guides) and its use in determining permanent disability in accordance with the Schedule for Rating Permanent Disabilities [effective January 1, 2005] (for all claims with dates of injury on or after January 1, 2005, and for those compensable claims arising before January 1, 2005, in which either there is no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notice to the injured worker required by Labor Code section 4061)

Causation

Determination of permanent and stationary status

Vocational rehabilitation (for claims with dates of injury prior to January 1, 2004)

Apportionment including the requirements of Labor Code sections 4660, 4663 and 4664 added by SB 899 (Stats. 2004, ch. 34)

Future medical treatment using the Medical Treatment Utilization Schedule

Review of records

Providing sufficient support for conclusions

(4) The Administrative Director's Disability Evaluation Protocols (minimum recommended 1 hour)

An overview of the Neuromusculoskeletal, Pulmonary, Cardiac, Immunologic, or Psychiatric protocols, and an in-depth discussion of measurement of impairment, calculations and rationale for rating under the AMA Guides, as relevant.

(5) The Third Party Perspective (minimum recommended 1 hour)

The report from the perspective of those who read it:

Judge(s), attorney(ies), insurer(s), rater(s), employer(s), qualified rehabilitation representative(s).

(6) Anatomy of a Good Report (small group or other interactive sessions -- minimum recommended 3 hours)

Discussion of examples of good reports and identification of weaknesses in reports

Opportunities for the practitioner to critique and/or correct reports.

If feasible, physician should have the opportunity to write a sample report.

Review of results of Administrative Director's annual report review and identification of common problems with reports.

(7) Mechanics of Report Writing (minimum recommended 1 hour)

The QME Process

Face to face time

Timelines for submission of report

Completion of required forms

Service of reports

Final questions and answers

(8) Submission and Critique of Written Medical/legal Report. As a condition of completion of the course taken to satisfy the requirements of this section, each physician enrollee shall draft at least one practice written medical/legal report, based on a sample case library of materials, which written report shall be critiqued with notations by the course education provider.

(j) All audio or video tapes, computer programs and printed educational material used in the course must be submitted to the Administrative Director on or before the date the course is first given. Up to the full twelve hours of instruction may be completed by distance learning whenever the Administrative Director has approved the submitted course prior to the first day the course is given. All distance learning materials shall bear a date of release and shall be updated yearly. The education provider shall notify the Administrative Director in writing of the revision.

(k) No one shall recruit members or promote commercial products or services in the instruction room immediately before, during, or immediately after the presentation of a course. Education providers or vendors may display/sell educational materials related to workers' compensation or applications for membership in an area adjoining a course. A course provider or faculty member shall disclose on QME Form 119 (Faculty Disclosure of Commercial Interest) (see, 8 Cal. Code Regs. § 119) any significant financial interest held by faculty in or affiliation with any commercial product or service which is discussed in a course and that interest or affiliation must be disclosed to all attendees. An education provider shall file every Form 119 in its possession with the Administrator Director.

(l) The provider shall maintain attendance records for each disability evaluation report writing course for a period of no less than three years after the course is given. A physician attending the course must be identified by signature. The provider must submit a copy of the signature list to the Administrative Director within 60 days of completion of the course.

(m) The provider is required to give the QME Evaluation Form 117 (Qualified Medical Evaluator Continuing Education Response Form) (see, 8 Cal. Code Regs. § 117) to course attendees and request they submit the form to the Administrative Director. This information shall not be used in lieu of a certification of completion given by the provider, as specified pursuant to section (n). Destruction by a provider or its employee of a QME's Evaluation Form or failure by such provider or its employee to distribute Form 117 as part of its course shall constitute grounds for revocation of a provider's accredited status. The Administrative Director shall tabulate the responses and return a summary to the provider within 90 days of completion of the course.

(n) The provider shall issue a certificate of completion to the physician that states the name of the provider, the provider's number, the date(s) and location and title of the course. To be eligible for appointment as a QME, a physician must complete no less than 12 hours of the curriculum specified in Section 11.5(i) and must submit a copy of that certificate to the Administrative Director.

(o) Joint sponsorship of courses (as between an accredited and an unaccredited provider) must be approved by the Administrative Director prior to presentation of the course.

(p) The Administrative Director may audit a provider's course(s) at the request of the medical director to determine if the provider meets the criteria for accreditation. The Administrative Director may audit courses given by providers randomly, when a complaint is received, or on the basis of responses on QME Form 117 (Qualified Medical Evaluator Continuing Education Response Form) (see, 8 Cal. Code Regs. § 117). An auditor shall not receive QME credit for auditing a course. The Administrative Director shall make written results of the audit available to the provider no more than 30 days after the audit is completed.

(q) Accredited providers that cease to offer disability evaluation report writing courses shall notify the Administrative Director in writing no later than 60 days prior to the discontinuing an approved course.

(r) The Administrative Director may withdraw accreditation of a provider or deny such a provider's application for accreditation on the following grounds (in addition to failure to meet the relevant requirements of subsections 11.5(a):

(1) Conviction of a felony or any offense substantially related to the activities of the provider.

(2) Any material misrepresentation of fact made by the provider.

(3) Failure to comply with Administrative Director regulations.

(4) False or misleading advertising.

(5) Failure to comply with Administrative Director's recommendations following an audit.

(6) Failure to distribute QME Form 117 (Qualified Medical Evaluator Continuing Education Response Form) (see, 8 Cal. Code Regs. § 117) cards to course attendees.

NOTE: Forms referred to above are available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 133, 139.2, 4060, 4061, 4062, 4062.1, 4062.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4061.5, 4062, 4062.1, 4062.2, 4062.3 and 4067, Labor Code.

HISTORY

1. New section filed 10-16-2000 as an emergency; operative 1-1-2001 (Register 2000, No. 42). A Certificate of Compliance must be transmitted to OAL by 5- 1-

2001 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 5-2-2001 as an emergency; operative 5-2-2001 (Register 2001, No. 18). A Certificate of Compliance must be transmitted to OAL by 8-30-2001 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 5-2-2001 order, including further amendment of section, transmitted to OAL 7-12-2001 and filed 8-23-2001 (Register 2001, No. 34).

4. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§12. Recognition of Specialty Boards.

The Administrative Director shall recognize only those specialty boards recognized by the respective California licensing boards for physicians as defined in Labor Code section 3209.3.

Note: Authority cited: Sections 133, 139.2, 139.4, 139.43, 139.45 and 5307.3, Labor Code. Reference: Sections 139.2(b)(3)(A) and 3209.3, Labor Code; Section 651(i), Business and Professions Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Amendment of section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

3. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§13. Physician's Specialty.

A physician's specialty(ies) is one for which the physician is board certified or, one for which a medical doctor or doctor of osteopathy has completed a postgraduate specialty training as defined in Section 11(a)(2)(A) or held an appointment as a QME in that specialty on June 30, 2000, pursuant to Labor Code Section 139.2. To be listed as a QME in a particular specialty, the physician's licensing board must recognize the designated specialty board and the applicant for QME status must have provided to the Administrative Director documentation from the relevant board of certification or qualification.

Note: Authority cited: Sections 133, 139.2, 139.4, 139.43, 139.45 and 5307.3, Labor Code. Reference: Section 139.2(b)(3)(A), Labor Code; and Section 651(i), Business and Professions Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Amendment of section filed 8-23-96; operative 9-22-96 (Register 96, No.34).

3. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

4. Amendment filed 8-23-2001; operative 8-23-2001 pursuant to GovernmentCode section 11343.4 (Register 2001, No. 34).

5. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§13.5. Chiropractic Certification in Workers' Compensation Evaluation. [Repealed]

Note:The "Physicians Guide" does not appear as a part of this regulation. Copies are available through the Executive Medical Director of the Industrial Medical Council; P.O. Box 8888 San Francisco, CA 94128-8888.

Note: Authority cited: Sections 139, 139.2 and 139.3, Labor Code. Reference: Sections 139.2, 4060, 4061 and 4062, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Change without regulatory effect amending subsection (a) filed 12-2-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 49).

3. Amendment filed 3-15-99; operative 4-14-99 (Register 99, No. 12).

4. Renumbering of former section 13.5 to section 14 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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§13.7. Appointment of Retired or Teaching Physicians. [Repealed]

Note: Authority cited: Sections 139 and 139.2, Labor Code. Reference: Sections 139.2, 4060, 4061 and 4062, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).
2. Amendment of opening paragraph and subsections (c)(2) and (c)(3) and new subsection (e) filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

3. Renumbering of former section 13.7 to section 15 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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§14. Doctors of Chiropractic: Certification in Workers' Compensation Evaluation

(a) All doctors of chiropractic shall be certified in workers' compensation evaluation by either a California professional chiropractic association, or an accredited California college recognized by the Administrative Director. The certification program shall include instruction in disability evaluation report writing that meets the standards set forth in section 11.5.

(b) California professional chiropractic associations or accredited California colleges applying to be recognized by the Administrative Director for the purpose of providing these required courses to chiropractors in California workers' compensation evaluation, shall meet the following criteria:

(1) The provider's courses shall be administered and taught by a California professional chiropractic association or a California chiropractic college accredited by the Council on Chiropractic Education. Instructors shall be licensed or certified in their profession or if a member of a non-regulated profession have at least two years experience in their area of instruction regarding workers' compensation issues.

(2) The provider's method of instruction and testing shall include all of the following:

(A) Lecture, didactic sessions and group discussion including an initial 8 hours of overview of the workers' compensation system and 36 additional hours in medical-legal issues for total minimum class time of 44 hours. Up to 4 hours of the instruction covering the regulations affecting QMEs and/or writing ratable reports may be satisfied by distance learning. The initial 8 hours of overview are transferable to any other approved program provider for credit;

(B) Passing a written test at the completion of the program to determine proficiency and application of course material;

(C) Writing a narrative conclusion to medical-legal issues in response to facts presented or a narrative report, in appropriate format, which would meet the standards of a ratable report;

(3) The initial 8 hours of the course material shall cover the following information:

(A) Overview of California Labor Code, DWC (Division of Workers' Compensation of the California Department of Industrial Relations) and the regulations of the Division of Workers' Compensation and of the Workers' Compensation Appeals Board governing QMEs, medical-legal reports and evaluations;

(B) Obligations of the treating and evaluating physicians;

(C) Review of appropriate workers' compensation terminology;

(4) The remaining 36 hours shall include but not be limited to the following:

(A) History and examination procedure requirements, including all relevant treatment, treatment utilization and evaluation guidelines and regulations adopted by the Administrative Director;

(B) The subjects outlined in subdivision 11.5(i) not already addressed in the first 8 hours, including but not limited to, proper use of the AMA Guides, the medical treatment utilization schedule (MTUS) adopted pursuant to Labor Code section 5307.27, and relevant portions of the ACOEM practice guidelines;

(C) Apportionment, including the changes in Labor Code sections 4660, 4663 and 4664 by SB 899 (Stats. 2004, ch. 34);

(D) Vocational rehabilitation;

(E) Continued and future medical care.

(5) The provider's course material and tests shall be submitted to the Administrative Director for annual review and the Administrative Director shall monitor a provider's course as necessary to determine if the provider meets the criteria for recognition.

(6) The provider's course advertising shall clearly state whether or not the course is recognized to satisfy the requirement for chiropractic California workers' compensation evaluation by the Administrative Director.

(c) Course Material shall also cover at a minimum, the material within the text of the "Physicians Guide to Medical Practice in the California Workers' Compensation System (Current Edition)."

(d) No one shall recruit members or promote commercial products or services in the instruction room immediately before, during, or immediately after the presentation of a course. Education providers or vendors may display/sell educational materials related to workers' compensation or applications for membership in an area adjoining a course. A course provider or faculty member shall disclose on QME Form 119 (Faculty Disclosure of Commercial Interest) (see, 8 Cal. Code Regs. § 119) any significant financial interest held by faculty in or affiliation with any commercial product or service which is discussed in a course and that interest or affiliation must be disclosed to all attendees. An education provider shall file every Form 119 in its possession with the Administrator Director.

Note: The "Physicians' Guide" does not appear as a part of this regulation. Copies are available through the Medical Director Division of Workers' Compensation, Attention: Medical Unit, P. O. Box 71010, Oakland, CA 94612.

Note: Authority cited: Sections 122, 133, 139.2, 139.3 and 5307.3, Labor Code. Reference: Sections 139.2, 4060,

4061, 4062, 4062.1, 4062.2, 4062.3 and 4067, Labor Code.

HISTORY

1. New section filed 4-9-93 as an emergency; operative 4-9-93 (Register 93, No. 15). A Certificate of Compliance must be transmitted to OAL 8-9-93 or emergency language will be repealed by operation of law on the following day.

2. Editorial correction amending subsections (a)(1) and (b) and Note(Register 93, No. 17).

3. New section refiled 9-16-93 with amendment of subsections (a)(1)-(b) as an emergency; operative 9-16-93 (Register 93, No. 38). A Certificate of Compliance must be transmitted to OAL by 1-14-94 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 9-16-93 order including amendment of subsections (b) and (c) transmitted to OAL 10-28-93 and filed 12-14-93 (Register 93, No. 51).

5. Relocation of article 2 filed 8-1-94; operative 8-31-94 (Register 94, No.31).

6. Amendment of subsections (a)(1) and (a)(2), repealer of subsections (b)-(b)(2) and subsection relettering, and amendment of newly designated subsections (b) and (c) filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

7. Amendment filed 6-7-99 as an emergency; operative 6-7-99 (Register 99, No. 24). A Certificate of Compliance must be transmitted to OAL by 10-5-99 or emergency language will be repealed by operation of law on the following day.

8. Reinstatement of section as it existed prior to 6-7-99 emergency amendment by operation of Government Code section 11346.1(f) (Register 2000, No.3).

9. Amendment filed 1-19-2000; operative 1-19-2000 pursuant to GovernmentCode section 11343.4(d) (Register 2000, No. 3).

10. Renumbering of former section 14 to section 16 filed 4-14-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 15).

11. Renumbering and amendment of former section 13.5 to section 14 filed 4-14- 2000; operative 5-14-2000 (Register 2000, No. 15).

12. Amendment of subsections (a), (b), (b)(4) and (b)(6) and redesignation and amendment of former subsection (b)(7) as new subsection (c) filed 8-23-2001; operative 8-23-2001 pursuant to Government Code section 11343.4 (Register 2001, No. 34).

13. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§15. Appointment of Retired or Teaching Physicians.

In order to be considered for appointment as a QME pursuant to Labor Code Section 139.2(c), a physician shall pass the QME competency examination and submit written documentation to the Administrative Director that he or she meets either (a), (b) or (c) of this section.

The physician shall:

(a) Be a current salaried faculty member at an accredited university or college, have a current license to practice as a physician and be engaged in teaching, lecturing, published writing or medical research at that university or college in the area of his or her specialty for not less than one-third of his or her professional time. The physician's practice in the three consecutive years immediately preceding the time of application shall not have been devoted solely to the forensic evaluation of disability.

(b) Be retired from full-time practice; retain a current license to practice in California as a physician with his or her licensing board; and

(1) Have a minimum of 25 years' experience in his or her practice as a physician; and

(2) Have had a minimum of 10 years' experience in workers' compensation medical issues; and

(3) Be practicing currently fewer than 10 hours per week on direct medical treatment as a physician; and

(4) Not have engaged in a practice devoted solely to the forensic evaluation of disability during the three consecutive years immediately preceding the time of application.

(c) Be retired from active practice due to a documented medical or physical disability as defined pursuant to Government Code section 12926 and currently practice in his or her specialty fewer than 10 hours per week. The physician shall have 10 years experience in workers' compensation medical issues as a physician. The physician's practice in the three consecutive years immediately preceding the time of application shall not have been devoted solely to the forensic evaluation of disability.

(d) A physician appointed under section 11 of Title 8 of the California Code of Regulations or this section shall, notify

the Administrative Director of changes in his or her status and shall complete the requirements for continuing education pursuant to section 55 of Title 8 of the California Code of Regulations prior to reappointment.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Section139.2, Labor Code.

HISTORY

1. New section filed 4-9-93 as an emergency; operative 4-9-93 (Register 93, No. 15). A Certificate of Compliance must be transmitted to OAL 8-9-93 or emergency language will be repealed by operation of law on the following day.

2. Editorial correction amending subsection (b) and Note(Register 93, No.17).

3. New section refiled 9-16-93 with amendment of subsections (a)(1)-(b) as an emergency; operative 9-16-93 (Register 93, No. 38). A Certificate of Compliance must be transmitted to OAL by 1-14-94 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 9-16-93 order including amendment of subsection (b) transmitted to OAL 10-28-93 and filed 12-14-93 (Register 93, No. 51).

5. Amendment filed 6-7-99 as an emergency; operative 6-7-99 (Register 99, No. 24). A Certificate of Compliance must be transmitted to OAL by 10-5-99 or emergency language will be repealed by operation of law on the following day.

6. Reinstatement of section as it existed prior to 6-7-99 emergency amendmentby operation of Government Code section 11346.1(f) (Register 2000, No.3).

7. Amendment filed 1-19-2000; operative 1-19-2000 pursuant to GovernmentCode section 11343.4(d) (Register 2000, No. 3).

8. Renumbering of former section 15 to section 17 filed 4-14-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No.15).

9. Renumbering and amendment former section 13.7 to section 15 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

10. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 2. QME Eligibility
New query

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§16. Determination of Fees for QME Eligibility.

(a) For purposes of establishing the annual fee for any qualified medical evaluator pursuant to Article 2, physicians (as defined under Section 3209.3 of the Labor Code) shall be classified into one of three categories:

(1) QMEs who meet all applicable requirements under Article 2 and 5 and who have conducted 0-10 comprehensive medical-legal evaluations in the twelve months prior to the assessment of the fee. Comprehensive medical-legal evaluations are evaluations as defined under Section (1)(i) of this Chapter performed by a physician.

(2) QMEs who meet all applicable requirements under Article 2 and 5 and who have conducted 11-24 comprehensive medical-legal evaluations in the twelve months prior to assessment of the fee. Comprehensive medical-legal evaluations are evaluations as defined under Section (1)(i) of this Chapter performed by a physician.

(3) QMEs who meet all applicable requirements under Article 2 and 5 and who have conducted 25 or more comprehensive medical-legal evaluations in the twelve months prior to assessment of the fee. Comprehensive medical-legal evaluations are evaluations as defined under Section (1)(i) of this Chapter performed by a physician.

(b) The evaluations shall be conducted in compliance with all applicable statutes and regulations.

(c) Verification of the number of examinations shall be made by the Administrative Director using The Qualified or Agreed Medical Evaluator Findings Summary Form in section 111 (See, 8 Cal. Code Regs. § 111), as well as any other relevant records or sources of information. Misrepresentation of the number of evaluations performed for purposes of establishing a physician's QME fee shall constitute grounds for disciplinary proceedings under section 60 of this chapter.

NOTE: Form referred to above is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Section 139.2, Labor Code.

HISTORY

1. New section filed 4-9-93 as an emergency; operative 4-9-
93 (Register 93, No. 15). A Certificate of Compliance must be transmitted to OAL 8-9-93 or
emergency language will be repealed by operation of law on the following day.

2. Editorial correction amending Note(Register 93, No. 17).

3. New section refiled 9-16-93 with amendment of subsection (a) as an emergency; operative 9-16-
93 (Register 93, No. 38). A Certificate of Compliance must be transmitted to OAL by 1-14-
94 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 9-16-93 order including amendments transmitted to OAL 10-28-93 and filed 12-14-93 (Register 93, No. 51).

5. Amendment of section filed 8-23-96; operative 9-22-96 (Register 96, No.34).

6. Amendment filed 6-7-99 as an emergency; operative 6-7-
99 (Register 99, No. 24). A Certificate of Compliance must be transmitted to OAL by 10-5-99
or emergency language will be repealed by operation of law on the following day.

7. Reinstatement of section as it existed prior to 6-7-99 emergency amendment by operation of Government Code section 11346.1(f) (Register 2000, No.3).

8. Amendment filed 1-19-2000; operative 1-19-2000 pursuant to GovernmentCode section
11343.4(d) (Register 2000, No. 3).

9. Renumbering of former section 16 to section 18 and renumbering of formersection 14 to number 16 filed 4-14-2000 pursuant to section 100, title 1,California Code of Regulations (Register 2000, No. 15).

10. Amendment of subsection (c) and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 2. QME Eligibility

New query

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§17. Fee Schedule for QME.

(a) For purposes of establishing the annual fee for any qualified medical evaluator pursuant to Article 2, physicians (as defined under Section 3209.3 of the Labor Code) shall be classified into one of three categories:

(1) QMEs who meet all applicable requirements under Article 2 and 5 and who have conducted 0-10 comprehensive medical-legal evaluations in the twelve months prior to the assessment of the fee. Comprehensive medical-legal evaluations are evaluations as defined under Section (1)(i) of this Chapter performed by a physician.

(2) QMEs who meet all applicable requirements under Article 2 and 5 and who have conducted 11-24 comprehensive medical-legal evaluations in the twelve months prior to assessment of the fee. Comprehensive medical-legal evaluations are evaluations as defined under Section (1)(i) of this Chapter performed by a physician.

(3) QMEs who meet all applicable requirements under Article 2 and 5 and who have conducted 25 or more comprehensive medical-legal evaluations in the twelve months prior to assessment of the fee. Comprehensive medical-legal evaluations are evaluations as defined under Section (1)(i) of this Chapter performed by a physician.

(b) The evaluations shall be conducted in compliance with all applicable statutes and regulations.

(c) Verification of the number of examinations shall be made by the Administrative Director using The Qualified or Agreed Medical Evaluator Findings Summary Form in section 111 (See, 8 Cal. Code Regs. § 111), as well as any other relevant records or sources of information. Misrepresentation of the number of evaluations performed for purposes of establishing a physician's QME fee shall constitute grounds for disciplinary proceedings under section 60 of this chapter.

NOTE: Form referred to above is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Section 139.2, Labor Code.

HISTORY

1. New section filed 4-9-93 as an emergency; operative 4-9-93 (Register 93, No. 15). A Certificate of Compliance must be transmitted to OAL 8-9-93 or emergency language will be repealed by operation of law on the following day.

2. Editorial correction amending Note(Register 93, No. 17).

3. New section refiled 9-16-93 with amendment of subsection (a) as an emergency; operative 9-16-93 (Register 93, No. 38). A Certificate of Compliance must be transmitted to OAL by 1-14-94 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 9-16-93 order including amendments transmitted to OAL 10-28-93 and filed 12-14-93 (Register 93, No. 51).

5. Amendment of section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

6. Amendment filed 6-7-99 as an emergency; operative 6-7-99 (Register 99, No. 24). A Certificate of Compliance must be transmitted to OAL by 10-5-99 or emergency language will be repealed by operation of law on the following day.

7. Reinstatement of section as it existed prior to 6-7-99 emergency amendment by operation of Government Code section 11346.1(f) (Register 2000, No. 3).

8. Amendment filed 1-19-2000; operative 1-19-2000 pursuant to GovernmentCode section 11343.4(d) (Register 2000, No. 3).

9. Renumbering of former section 16 to section 18 and renumbering of former section 14 to number 16 filed 4-14-2000 pursuant to section 100, title 1,California Code of Regulations (Register 2000, No. 15).

10. Amendment of subsection (c) and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 2. QME Eligibility
New query

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§18. QME Fee Due Dates.

(a) All physicians, regardless of the number of comprehensive medical-legal evaluations performed under section 17 of Title 8 of the California Code of Regulations shall pay the required QME fees at yearly intervals within 30 days of receipt of notice from the Administrative Director that the QME fee for the next 12 months is due and payable. No physician who has passed the competency examination shall be placed on the active QME roster until the appropriate fee under section 17 has been paid.

(b) Any QME who fails to pay the required statutory fee within 30 days of receipt of a final notice that the fee is due shall be notified that he or she shall be terminated from the official QME roster of physicians within 30 days and shall not perform any panel QME or represented QME comprehensive medical-legal evaluation until the fee is paid.

(c) If the QME fee is not paid within two years from the due date in the final fee notice from the Administrative Director to the QME or QME applicant that the fee is due, then the physician shall resubmit a new application pursuant to Sections 10 and 11 of Title 8 of the California Code of Regulations, pass the QME competency examination and pay the appropriate fee prior to regaining or obtaining QME active status.
Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Section139.2, Labor Code.

HISTORY

1. New section filed 4-9-93 as an emergency; operative 4-9-93 (Register 93, No. 15). A Certificate of Compliance must be transmitted to OAL 8-9-93 or emergency language will be repealed by operation of law on the following day.

2. Editorial correction amending subsections (b) and (b)(1) and Note(Register 93, No. 17).

3. New section refiled 9-16-93 with amendment of section heading and text as an emergency; operative 9-16-93 (Register 93, No. 38). A Certificate of Compliance must be transmitted to OAL by 1-14-94 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 9-16-93 order including amendments transmitted to OAL 10-28-93 and filed 12-14-93 (Register 93, No. 51).

5. Repealer filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

6. Renumbering of former section 16 to section 18 filed 4-14-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 15).

7. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 2. QME Eligibility

New query

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§19. Certificate of QME Status.

(a) Upon receipt of the QME fees and review by the Administrative Director to ensure current compliance with section 139.2 of Labor Code and any other applicable regulations promulgated by the Administrative Director concerning QME eligibility, the Administrative Director shall within 45 days send to the physician a Qualified Medical Evaluator certificate. The QME certificate shall be displayed in a conspicuous manner at the QME's office location at all times during the period the QME is appointed by the Administrative Director to conduct evaluations.

(b) It shall be unlawful for any physician who has been terminated or suspended from the QME list or who has failed to pay the required QME fee pursuant to sections 17 and 18 of Title 8 of the California Code of Regulations to display a Qualified Medical Evaluator certificate.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Section139.2, Labor Code.

HISTORY

1. Renumbering and amendment of former section 17 to new section 19 filed 4- 14-2000; operative 5-14-2000 (Register 2000, No. 15).

2. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 2.5. Time Periods for Processing Applications for QME Status

New query

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§20. Time Periods.

(a) Within 45 days of receipt of an application for QME status, the Administrative Director shall either inform the applicant, in writing, that the application is complete and accepted for filing, or that the application is deficient and what specific information is required.

(b) Within 45 days of receipt of a completed application, the Administrative Director shall inform the applicant, in writing, of its decision to allow or not to allow the applicant to proceed to take the required QME competency examination as per Section 11(f) of Title 8 of the California Code of Regulations.

(c) Within 45 days of receipt of a completed application, the Administrative Director must inform the applicant, in writing, of its decision to grant or deny the application.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 4060, 4061, 4062, 4062.1, 4062.2 and 4067, Labor Code.

HISTORY

1. New article 2.5 and section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 3. Assignment of Qualified Medical Evaluators, Evaluation Procedure

New query

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§29. Specified Financial Interests That May Affect Assignment to QME Panels.

(a) Every physician seeking appointment or reappointment as a Qualified Medical Evaluator shall disclose specified financial interests, as defined in section 1 (dd) and 29(b) of Title 8 of the California Code of Regulations.

(b) "Specified Financial Interests" means being a general partner or limited partner in, or having an interest of five (5) percent or more in, or receiving or being legally entitled to receive a share of five (5) percent or more of the profits from, any medical practice, group practice, medical group, professional corporation, limited liability corporation, clinic or other entity that provides treatment or medical evaluation, goods or services for use in the California workers' compensation system.

(c) "SFI Form 124", as used in sections 1 though 159 of Title 8 of the California Code of Regulations, means the QME SFI Form 124 that is completed and filed as an attachment to QME Form 100, 103 or 104 by the physician or QME with the Medical Director of the Division of Workers' Compensation.

(d) Specified financial interests shall be disclosed on QME SFI Form 124, respectively, when applying for appointment on QME Form 100, at the time of paying the annual fee on QME Form 103 or when applying for reappointment on QME Form 104.

(e) The completed QME SFI Form 124 shall be filed along with the QME Form 100, 103 or 104, respectively, when the form is filed with the Medical Director of the Division of Workers' Compensation.

(f) Failure of a Qualified Medical Evaluator to complete and file a QME SFI Form 124 with the Medical Director when required by this section shall be grounds for disciplinary action pursuant to section 60 of Title 8 of the California Code of Regulations.

(g) The Administrative Director shall use the information provided by physicians pursuant to this section to avoid assigning QMEs who share specified financial interests to the same QME panel. If two or more QMEs assigned to a panel share specified financial interests as defined in this section, any party may request a replacement QME. If three QMEs share specified financial interests as defined in this section, two of the QMEs shall be replaced. If two QMEs share specified financial interests as defined in this section, one of the QMEs shall be replaced. The QMEs that must be replaced shall be randomly selected by the Medical Director.

NOTE: Forms referred to above are available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2 and 4067, Labor Code.

HISTORY

1. New section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§30. QME Panel Requests.

(a) Unrepresented cases. Whenever an injured worker is not represented by an attorney and either the employee or the claims administrator requests a QME panel pursuant to Labor Code section 4062.1, the request shall be submitted on the form in section 105 (Request for QME Panel under Labor Code Section 4062.1)(See, 8 Cal. Code Regs. § 105). The claims administrator (or if none the employer) shall provide Form 105 along with the Attachment to Form 105 (How to Request a Qualified Medical Evaluator if you do not have an Attorney) to the unrepresented employee by means of personal delivery or by first class or certified mailing.

(b) Represented cases. Requests for a QME panel in a represented case, for all cases with a date of injury on or after January 1, 2005, and for all other cases where represented parties agree to obtain a panel of Qualified Medical Evaluators pursuant to the process in Labor Code section 4062.2, shall be submitted on the form in section 106 (Request for a QME Panel under Labor Code Section 4062.2)(See, 8 Cal. Code Regs. § 106). The party requesting a QME panel shall: 1) identify the disputed issue that requires a comprehensive medical/legal report to be resolved; 2) attach a copy of the written proposal, naming one or more physicians to be an Agreed Medical Evaluator, that was sent to the opposing party once the dispute arose; 3) designate a specialty for the QME panel requested; 4) state the specialty preferred by the opposing party, if known; and 5) state the specialty of the treating physician. In represented cases with dates of injury prior to January 1, 2005, and only upon the parties' agreement to obtain a QME panel pursuant to Labor Code section 4062.2, the party requesting a QME panel shall submit QME Form 106 in compliance with this section and provide written evidence of the parties' agreement. Once such a panel in a represented case with a date of injury prior to January 1, 2005, is issued, the parties shall be bound by the timelines and process as described in Labor Code section 4062.2.

(c) In the event a request form is incomplete, or improperly completed, so that a QME panel selection cannot properly be made, the request form shall be returned to the requesting party with an explanation of why the QME panel selection could not be made. The Medical Director also may delay issuing a new QME panel, if necessary, until the Medical Director receives additional reasonable information requested from a party or both parties, needed to resolve the panel request. Reasonable information as used in this subdivision includes but is not limited to whether a QME panel previously issued to the injured worker was used.

(d)(1) After a claim form has been filed, the claims administrator, or if none the employer, may request a panel of Qualified Medical Evaluators only as provided in Labor Code section 4060, to determine whether to accept or reject a claim within the ninety (90) day period for rejecting liability in Labor Code section 5402(b), and only after providing

evidence of compliance with Labor Code Section 4062.1 or 4062.2.

(d)(2) Once the claims administrator, or if none the employer, has accepted as compensable injury to any body part in the claim, a request for a panel QME may only be filed based on a dispute arising under Labor Code section 4061 or 4062.

(d)(3) Whenever an injury or illness claim of an employee has been denied entirely by the claims administrator, or if none by the employer, only the employee may request a panel of Qualified Medical Evaluators, as provided in Labor Code sections 4060(d) and 4062.1 if unrepresented, or as provided in Labor Code sections 4060(c) and 4062.2 if represented.

(d)(4) After the ninety (90) day period specified in Labor Code section 5402(b) for denying liability has expired, a request from the claims administrator, or if none from the employer, for a QME panel to determine compensability shall only be issued upon presentation of a finding and decision issued by a Workers' Compensation Administrative Law Judge that the presumption in section 5402(b) has been rebutted and an order that a QME panel should be issued to determine compensability. The order shall also specify the residential or, if applicable, the employment-based zip code from which to select evaluators and either the medical specialty of the panel or which party may select the medical specialty.

(e) If the request form is submitted by or on behalf of an employee who no longer resides within the state of California, the geographic area of the QME panel selection within the state shall be determined by agreement between the claims administrator, or if none the employer, and the employee. If no agreement can be reached, the geographic area of the QME panel selection shall be determined for an unrepresented employee by the employee's former residence within the state, and for a represented employee by the office of the employee's attorney.

(f) To compile a panel list of three (3) independent QMEs randomly selected from the specialty designated by the party holding the legal right to request a QME panel, the Medical Director shall exclude from the panel, to the extent feasible, any QME who is listed by another QME as a business partner or as having a shared specified financial interest, as those terms are defined in sections 1 and 29 of Title 8 of the California Code of Regulations.

(g) The panel request in a represented case must be sent to the Medical Unit address on the QME Form 106 by means of first class mail delivered by the United States postal service. The Medical Unit will not accept panel requests in represented cases that are delivered in person by a party, the party's attorney, any other person or by other commercial courier or delivery services.

(h) The time periods specified in Labor Code sections 4062.1(c) and 4062.2(c), respectively, for selecting an evaluator from a QME panel and for scheduling an appointment, shall be tolled whenever the Medical Director asks a party for additional information needed to resolve the panel request. These time periods shall remain tolled until the date the Medical Director issues either a new QME panel or a decision on the panel request.

NOTE: Forms referred to above are available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 133, 139.2, 4061, 4062 and 5307.3, Labor Code. Reference: Sections 139.2, 4061, 4062, 4062.1, 4062.2, 4062.3, 4064 and 4067, Labor Code.

HISTORY

1. New article 3 and section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Amendment of subsection (b) and new subsections (d)-(e) filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

3. Amendment of subsections (a), (c) and (d)(1) filed 4-14-2000; operative 5- 14-2000 (Register 2000, No. 15).

4. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§30.1. The Request for Qualified Medical Evaluator Form. (Repealed)

Note: Authority cited: Sections 133, 139 and 139.2, Labor Code. Reference: Sections 139.2, 4060, 4061 and 4062, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Change without regulatory effect amending specialty codes filed 6-27-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 26).

3. Editorial correction adding History3 and including previously filed amendments (Register 95, No. 41).

4. Change without regulatory effect amending specialty code MPT, repealing specialty codes DDS and DMD and adding specialty code DEN filed 10-11-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 41).

5. Change without regulatory effect adding MAP specialty code filed 12-27-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 52).

6. Change without regulatory effect amending form filed 6-20-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 25).

7. Change without regulatory effect amending form filed 2-25-97 pursuant to section 100, title 1, California Code of Regulations (Register 97, No. 9).

8. Change without regulatory effect amending MD/DO specialty codes filed 6-19-97 pursuant to section 100, title 1, California Code of Regulations (Register 97, No. 25).

9. Change without regulatory effect amending MD/DO speciality codes and updating form revision date filed 4-15-98 pursuant to section 100, title 1,California Code of Regulations (Register 98, No. 16).

10. Change without regulatory effect amending MD/DO specialty codes and updating form revision date filed 7-12-99 pursuant to section 100, title 1,California Code of Regulations (Register 99, No. 29).

11. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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New query

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§30.2. 30.2. The Request for Qualified Medical Evaluator Instruction Form. (Repealed)

NOTE: Authority cited: Sections 133, 139 and 139.2, Labor Code. Reference: Sections 139.2, 4060, 4061 and 4062, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Change without regulatory effect amending thrid paragraph filed 2-25-97 pursuant to section 100, title 1, California Code of Regulations (Register 97, No. 9).

3. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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New query

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§30.5. Specialist Designation.

The Medical Director shall utilize in the QME panel selection process the type of specialist(s) indicated by the requestor on the Request for Qualified Medical Evaluator Form 105 or 106 of Title 8 of the California Code of Regulations, unless otherwise provided in these regulations.

Note: Authority cited: Sections 133, 139.2, 4061, 4062 and 5307.3, Labor Code. Reference: Sections 139.2, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. Renumbering and amendment of former section 32 to new section 30.5 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

2. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§31. QME Panel Selection.

(a) The panels shall be selected randomly from the appropriate specialty identified by the party who holds the legal right to designate the specialty, with consideration given to the proximity of the QME's medical office to the employee's residence.

(b) The Medical Director shall exclude from the panel selection process any QME who has informed the Medical Director that he or she is unavailable pursuant to section 33 of Title 8 of the California Code of Regulations.

(c) Any physician who has served as a primary treating physician or secondary physician and who has provided treatment to the employee in accordance with section 9785 of Title 8 of the California Code of Regulations for the disputed injury shall not perform a QME evaluation on that employee. Whenever that physician's name appears on a QME panel, he or she shall disqualify him or herself if contacted by a party to perform the evaluation. Either party may request a replacement QME for this reason pursuant to section 31.5 of Title 8 of the California Code of Regulations.

(d) To issue a panel in a selected specialty there shall be at least five active QMEs in the specialty at the time the panel selection is requested. In the event less than five QMEs are active in a requested specialty, the Medical Director shall contact the party who holds the legal right to designate the specialty for an alternate specialty selection.

Note: Authority cited: Sections 133, 139.2, 4061, 4062 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Repealer of subsection (d) and subsection relettering, and amendment of newly designated subsection (d) filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

3. Amendment of subsections (b) and (d) filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

4. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§31.1. QME Panel Selection Disputes in Represented Cases.

(a) When the Medical Director receives two or more panel selection forms pursuant to Labor Code section 4062.2 on the same day and the forms designate different physician specialties for the QME panel, the Medical Director shall use the following procedures:

1) If one party requests the same specialty as that of the treating physician, the panel shall be issued in the specialty of the treating physician unless the Medical Director is persuaded by supporting documentation provided by the requestor that explains the medical basis for the requested specialty;

2) If no party requests a panel in the specialty of the treating physician, the Medical Director shall select a specialty appropriate for the medical issue in dispute and issue a panel in that specialty.

3) Upon request by the Medical Director, the party requesting the panel shall provide additional medical records to assist the Medical Director in determining the appropriate specialty.

(b) In the event a party in a represented case wishes to request a QME panel pursuant to Labor Code section 4062.2 in a specialty other than the specialty of the treating physician, the party shall submit with the panel request form any relevant documentation supporting the reason for requesting a different specialty.

(c) In the event the Medical Director is unable to issue a QME panel in a represented case within thirty (30) calendar days of receiving the request, either party may seek an order from a Workers' Compensation Administrative Law Judge that a QME panel be issued. Any such order shall specify the specialty of the QME panel or the party to be designated to select the specialty.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 4060, 4061, 4062, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

For prior history, see Register 2000, No. 15.

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§31.2. The Qualified Medical Evaluator Panel Selection Instruction Form. (Repealed)

Note: Authority cited: Sections 133, 139, 139.2, 4061 and 4062, Labor Code. Reference: Sections 139.2, 4061, 4061.5 and 4062, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Amendment of section heading and form filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

3. Change without regulatory effect amending paragraph 1) filed 2-25-97 pursuant to section 100, title 1, California Code of Regulations (Register 97, No. 9).

4. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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§31.3. Scheduling Appointment with Panel QME.

(a) When the employee is not represented by an attorney, the unrepresented employee shall, within ten (10) days of having been furnished with the form, select a QME from the panel list, contact the QME to schedule an appointment and inform the claims administrator of the QME selection and the appointment.

(b) Neither the employer, nor the claims administrator nor any other representative of the employer shall discuss the selection of the QME with an unrepresented worker who has the legal right to select the QME.

(c) If, within ten (10) days of the issuance of a QME panel, the unrepresented employee fails to select a QME from the QME panel or fails to schedule an appointment with the selected QME, the claims administrator may schedule an appointment with a panel QME only as provided in Labor Code section 4062.1(c), and shall notify the employee of the appointment as provided in that section.

(d) Whenever the employee is represented by an attorney and the parties have completed the conferring and striking processes described in Labor Code section 4062.2(c), the represented employee shall schedule the appointment with the physician selected from the QME panel. If the represented employee fails to do so within ten (10) business days of the date a QME is selected from the panel, the claims administrator or administrator's attorney may arrange the appointment and notify the employee and employee's attorney.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§31.5. QME Replacement Requests.

(a) A replacement QME to a panel, or at the discretion of the Medical Director a replacement of an entire panel of QMEs, shall be selected at random by the Medical Director and provided upon request whenever any of the following occurs:

(1) A QME on the panel issued does not practice in the specialty requested by the party holding the legal right to request the panel.

(2) A QME on the panel issued cannot schedule an examination for the employee within sixty (60) days of the initial request for an appointment, or if the 60 day scheduling limit has been waived pursuant to section 33(e) of Title 8 of the California Code of Regulations, the QME cannot schedule the examination within ninety (90) days of the date of the initial request for an appointment.

(3) The injured worker has changed his or her residence address since the QME panel was issued and prior to date of the initial evaluation of the injured worker.

(4) A physician on the QME panel is a member of the same group practice as defined by Labor Code section 139.3 as another QME on the panel.

(5) The QME is unavailable pursuant to section 33 (Unavailability of the QME).

(6) The evaluator who previously reported in the case is no longer available.

(7) A QME named on the panel is currently, or has been, the employee's primary treating physician or secondary physician as described in section 9785 of Title 8 of the California Code of Regulations for the injury currently in dispute.

(8) The claims administrator, or if none the employer, and the employee agree in writing, for the employee's

convenience only, that a new panel may be issued in the geographic area of the employee's work place and a copy of the employee's agreement is submitted with the panel replacement request.

(9) The Medical Director, upon written request, finds good cause that a replacement QME or a replacement panel is appropriate for reasons related to the medical nature of the injury. For purposes of this subsection, "good cause" is defined as a documented medical or psychological impairment.

(10) The Medical Director, upon written request, filed with a copy of the Doctor's First Report of Occupational Injury or Illness (Form DLSR 5021 [see 8 Cal. Code Regs. §§ 14006 and 14007) and the most recent DWC Form PR-2 ("Primary Treating Physician's Progress Report" [See 8 Cal. Code Regs. § 9785.2) or narrative report filed in lieu of the PR-2, determines after a review of all appropriate records that the specialty chosen by the party holding the legal right to designate a specialty is medically or otherwise inappropriate for the disputed medical issue(s). The Medical Director may request either party to provide additional information or records necessary for the determination.

(11) The evaluator has violated section 34 (Appointment Notification and Cancellation) of Title 8 of the California Code of Regulations, except that the evaluator will not be replaced for this reason whenever the request for a replacement by a party is made more than fifteen (15) calendar days from either the date the party became aware of the violation of section 34 of Title 8 of the California Code of Regulations or the date the report was served by the evaluator, whichever is earlier.

(12) The evaluator failed to meet the deadlines specified in Labor Code section 4062.5 and section 38 (Medical Evaluation Time Frames) of Title 8 of the California Code of Regulations and the party requesting the replacement objected to the report on the grounds of lateness prior to the date the evaluator served the report. A party requesting a replacement on this ground shall attach to the request for a replacement a copy of the party's objection to the untimely report.

(13) The QME has a disqualifying conflict of interest as defined in section 41.5 of Title 8 of the California Code of Regulations.

(14) The Administrative Director has issued an order pursuant to section 10164(c) of Title 8 of the California Code of Regulations (order for additional QME evaluation).

(15) The selected medical evaluator, who otherwise appears to be qualified and competent to address all disputed medical issues refuses to provide, when requested by a party or by the Medical Director, either: A) a complete medical evaluation as provided in Labor Code sections 4062.3(i) and 4062.3(j), or B) a written statement that explains why the evaluator believes he or she is not medically qualified or medically competent to address one or more issues in dispute in the case.

(16) The QME panel list was issued more than twenty four (24) months prior to the date the request for a replacement is received by the Medical Unit, and none of the QMEs on the panel list have examined the injured worker.

(b) Whenever the Medical Director determines that a request made pursuant to subdivision 31.5(a) for a QME replacement or QME panel replacement is valid, the time limit for an unrepresented employee to select a QME and

schedule an appointment under section Labor Code section 4062.1(c) and the time limit for a represented employee to strike a QME name from the QME panel under Labor Code section 4062.2(c), shall be tolled until the date the replacement QME name or QME panel is issued.

(c) In the event the parties in a represented case have struck two QME names from a panel and subsequently a valid ground under subdivision 31.5 arises to replace the remaining QME, none of the QMEs whose names appeared on the earlier QME panel shall be included in the replacement QME panel.

Note: Authority cited: Sections 133, 139.2, 4061, 4062, 4062.3, 4062.5, 5307.3 and 5703.5, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4062.3, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

2. Amendment of subsections (b), (b)(1) and (b)(3) and new subsections (b)(4)-(5) filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§31.7. Obtaining Additional QME Panel in a Different Specialty.

(a) Once an Agreed Medical Evaluator, an Agreed Panel QME, or a panel Qualified Medical Evaluator has issued a comprehensive medical/legal report in a case and a new medical dispute arises, the parties, to the extent possible, shall obtain a follow-up evaluation or a supplemental evaluation from the same evaluator.

(b) Upon a showing of good cause that a panel of QME physicians in a different specialty is needed to assist the parties reach an expeditious and just resolution of disputed medical issues in the case, the Medical Director shall issue an additional panel of QME physicians selected at random in the specialty requested. For the purpose of this section, good cause means:

(1) An order by a Workers' Compensation Administrative Law Judge for a panel of QME physicians that also either designates a party to select the specialty or states the specialty to be selected and the residential or employment-based zip code from which to randomly select evaluators; or

(2) The AME or QME selected advises the parties and the Medical Director, or his or her designee, that she or he has completed or will complete a timely evaluation of the disputed medical issues within his or her scope of practice and areas of clinical competence but recommends that a new evaluator in another specialty is needed to evaluate one or more remaining disputed medical conditions, injuries or issues that are outside of the evaluator's areas of clinical competence, and either the injured worker is unrepresented or the parties in a represented case have been unable to select an Agreed Medical Evaluator for that purpose; or

(3) A written agreement by the parties in a represented case that there is a need for an additional comprehensive medical legal report by an evaluator in a different specialty, that attempts to select an Agreed Medical Evaluator pursuant to Labor Code section 4062.2 for that purpose have failed and the specialty that the parties have agreed upon for the additional evaluation; or

(4) In an unrepresented case, that the parties have conferred with an Information and Assistance Officer, have explained the need for an additional QME evaluator in another specialty to address disputed issues and, as noted by the Information and Assistance Officer on the panel request form, the parties have reached agreement in the presence of and with the assistance of the Officer on the specialty requested for the additional QME panel. The parties may confer with the Information and Assistance Officer in person or by conference call.

Note: Authority cited: Sections 133, 139.2, 4061, 4062, 4062.3, 4062.5, 5307.3 and 5703.5, Labor Code. Reference: Sections 139.2, 4061, 4062, 4062.1, 4062.2, 4062.3, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§32. Consultations.

(a) In any case where an acupuncturist has been selected by the injured worker from a three-member panel and an issue of disability is in dispute, the acupuncturist shall request a consult from a QME defined under section 1(z) to evaluate the disability issue(s). The acupuncturist shall evaluate all other issues as required for a complete evaluation. If requested by the QME acupuncturist to obtain a QME to provide the consulting evaluation, the Medical Director shall issue a panel within fifteen (15) days of the request in the specialty selected by the QME acupuncturist.
(b) Except as provided in subdivision 32(a) above, no QME may obtain a consultation for the purpose of obtaining an opinion regarding permanent disability and apportionment consistent with the requirements of Labor Code sections 4660 through 4664 and the AMA Guides.

(c) For injuries occurring on or after January 1, 1994, a QME may obtain a consultation from any physician as reasonable and necessary pursuant to Labor Code section 4064(a).

(d) Whenever an Agreed Panel QME or a QME determines that a consultation is necessary pursuant to this section and the physician selected for the consultation is not selected by the parties from a QME panel issued by the Medical Director, the referring QME must arrange the consultation appointment and advise the injured employee and the claims administrator, or if none the employer, and each party's attorney if any, in writing of the appointment date, time and place by use of QME Form 110 (QME Appointment Notification Form)(See, 8 Cal. Code Regs. § 110).

(e) The consulting physician shall serve the consulting report on the referring QME. Upon receipt of the consulting physician's report, the referring evaluator shall review the consulting physician's report, incorporate that report by reference into the referring evaluator's medical-legal report and comment on the consulting physician's findings and conclusions in the discussion sections of the evaluator's report.

(f) The referring QME shall file the comprehensive medical-legal report within the time periods specified in section 38 of Title 8 of the California Code of Regulations. In the event a consulting physician's report has not been received, or will not be received, in time to comply with the time periods, the referring QME shall serve the comprehensive medical-legal report timely, and upon receipt of the consulting physician's report, the referring evaluator shall, within fifteen (15) calendar days of receipt of the consulting report, issue a supplemental report that incorporates the consulting physician's report by reference, and comments on whether and how the findings in the consulting report change the referring evaluator's opinions. The referring evaluator shall list, in the report commenting on a consulting physician's report, all reports and information received from each party for the consulting physician, indicate whether each item was forwarded to the consulting physician, and for items not forwarded the reason the referring evaluator determined it was not necessary to forward the item to the consulting physician.

(g) With the exception of verbal communications between an injured worker and the consulting physician in the course of the consulting examination, all other communications by the parties, as well as any reports and other information from the parties for the consulting physician, if any, shall be made in writing directed only to the referring QME, who may forward such communications on to the consulting physician as appropriate. With the exception of deposing the consulting physician if necessary and except as provided in this subdivision, neither party nor a party's attorney, shall communicate directly with nor send correspondence or records directly to the consulting physician.

NOTE: Form referred to above is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 133, 139.2, 4061, 4062, 4064, 5307.3 and 5703.5, Labor Code. Reference: Sections 3209.3, 4061, 4062, 4062.1, 4062.2, 4064, 4067 and 5703.5, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Renumbering of former section 32 to new section 30.5 and renumbering and amendment of former section 32.5 to section 32 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§32.5. [Reserved]

Note: Authority cited: Sections 139.2, 4061, 4062 and 4064, Labor Code. Reference: Sections 4061 and 4062, Labor Code.

HISTORY

1. New section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).
2. Renumbering of former section 32.5 to section 32 and renumbering and amendment of former section 32.7 to section 32.5 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Repealer filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§32.7. Rebuttal QME Examinations. [Renumbered]

Note: Authority cited: Sections 139.2, 4061 and 4062, Labor Code. Reference: Sections 4061 and 4064, Labor Code.

HISTORY

1. New section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).
2. Renumbering of former section 32.7 to section 32.5 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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§33. Unavailability of QME.

(a) A QME who will be unavailable to schedule or perform comprehensive medical evaluations as an Agreed Panel QME or as a Panel QME for a period of 14 days, or up to a maximum of 90 days during a one year fee period, for any reason shall notify the Medical Director by submitting the form in Section 109 (Notice of Qualified Medical Evaluator Unavailability) (see, 8 Cal. Code Regs. § 109) at least 30 days before the period of unavailability is to begin. The Medical Director may, in his or her discretion, grant unavailable status within the 30-day notice period for good cause, including but not limited to medical or family emergency.

(b) At the time of requesting unavailable status, the QME shall provide the Medical Director with a list of any and all comprehensive medical/legal evaluation examinations already scheduled during the time requested for unavailable status. The QME shall indicate whether each such examination is being rescheduled or the QME plans to complete the exam and report while in unavailable status.

(c) A QME who is unavailable as provided in subdivision (a) shall not perform any new evaluation examinations as a QME until the physician returns to active QME status. Such a QME may complete medical-legal examinations and reports already scheduled and reported to the Medical Director, as well as reports for evaluation examinations performed prior to becoming unavailable under subdivision (a). Such a QME also may complete supplemental reports.

(d) It shall not be an acceptable reason for unavailability that a QME does not intend to perform comprehensive medical-legal evaluations for unrepresented workers. A QME who has filed notifications for unavailability totaling more than ninety (90) days during the QME fee period without good cause may be denied reappointment subject to section 52 of Title 8 of the California Code of Regulations. Good cause includes, but is not limited to, sabbaticals, or death or serious illness of an immediate family member.

(e) If a party with the legal right to schedule an appointment with a QME is unable to obtain an appointment with a selected QME within sixty (60) days of the date of the appointment request, that party may waive the right to a replacement in order to accept an appointment no more than ninety (90) days after the date of the party's initial appointment request. When the selected QME is unable to schedule the evaluation within ninety (90) days of the date of that party's initial appointment request, either party may report the unavailability of the QME and the Medical Director shall issue a replacement pursuant to section 31.5 of Title 8 of the California Code of Regulations upon request, unless both parties agree in writing to waive the ninety (90) day time limit for scheduling the initial evaluation.

(f) If a QME fails to notify the Medical Director, by submitting the form in section 109 (Notice of Qualified Medical Evaluator Unavailability) (see, 8 Cal. Code Regs. § 109), of his or her unavailability at a medical office at least thirty

(30) days prior to the period the evaluator becomes unavailable, the Medical Director may designate the QME to be unavailable at that location for thirty (30) days from the date the Medical Director learns of the unavailability.

(g) Whenever the Medical Director is notified by a party seeking an appointment with a Qualified Medical Evaluator, or otherwise becomes aware, that the QME is not available and not responding to calls or mail at a location listed for the QME, a certified letter will be sent to the QME by the Medical Director regarding his/her unavailability. If the Medical Director does not receive a response within fifteen (15) days of the date the certified letter is mailed, then the QME will be made unavailable at that location. The time a QME is placed on unavailable status pursuant to this subdivision shall count toward the ninety (90) day limit in subdivision 33(a) of Title 8 of the California Code of Regulations.

NOTE: Form referred to above is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4062.5 and 4067, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§33.1. The Notice of QME Unavailability Form. [Repealed]

NOTE: Authority cited: Sections 139 and 139.2, Labor Code. Reference: Sections 139.2, 4061 and 4062, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Amendment of section heading, repealer and new section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

3. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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§34. Appointment Notification and Cancellation.

(a) Whenever an appointment for a comprehensive medical evaluation is made with a QME, the QME shall complete an appointment notification form by submitting the form in Section 110 (QME Appointment Notification Form)(See, 8 Cal. Code Regs. § 110). The completed form shall be postmarked or sent by facsimile to the employee and the claims administrator, or if none the employer, within 5 business days of the date the appointment was made. In a represented case, a copy of the completed form shall also be sent to the attorney who represents each party, if known. Failure to comply with this requirement shall constitute grounds for denial of reappointment under section 51 of Title 8 of the California Code of Regulations.

(b) The QME shall schedule an appointment for a comprehensive medical-legal examination which shall be conducted only at the medical office listed on the panel selection form. However, upon written request by the injured worker and only for his or her convenience, the evaluation appointment may be moved to another medical office of the selected QME if it is listed with the Medical Director as an additional office location.

(c) The QME shall include within the notification whether a Certified Interpreter, as defined by Labor Code Section 5811 and subject to the provisions of section 9795.3 of Title 8 of the California Code of Regulations, is required and specify the language. The interpreter shall be arranged by the party who is to pay the cost as provided for in Section 5811 of the Labor Code.

(d) An evaluator, whether an AME, Agreed Panel QME or QME, shall not cancel a scheduled appointment less than six (6) business days prior to the appointment date, except for good cause. Whenever an evaluator cancels a scheduled appointment, the evaluator shall advise the parties in writing of the reason for the cancellation. The Appeals Board shall retain jurisdiction to resolve disputes among the parties regarding whether an appointment cancellation pursuant to this subdivision was for good cause. The Administrative Director shall retain jurisdiction to take appropriate disciplinary action against any Agreed Panel QME or QME for violations of this section.

(e) An Agreed Panel QME or a QME who cancels a scheduled appointment shall reschedule the appointment to a date within thirty (30) calendar days of the date of cancellation. The re-scheduled appointment date may not be more than sixty (60) calendar days from the date of the initial request for an appointment, unless the parties agree in writing to accept the date beyond the sixty (60) day limit.

(f) An Agreed Medical Evaluator who cancels a scheduled appointment shall reschedule the appointment within sixty (60) calendar days of the date of the cancellation, unless the parties agree in writing to accept an appointment date no more than thirty (30) calendar days beyond the sixty (60) day limit.

(g) Failure to receive relevant medical records, as provided in section 35 of Title 8 of the California Code of Regulations and section 4062.3 of the Labor Code, prior to a scheduled appointment shall not constitute good cause under this section for the evaluator to cancel the appointment, unless the evaluator is a psychiatrist or psychologist performing an evaluation regarding a disputed injury to the psyche who states in the evaluation report that receipt of relevant medical records prior to the evaluation was necessary to conduct a full and fair evaluation.

(h) An appointment scheduled with an evaluator, whether an AME, Agreed Panel QME or QME shall not be cancelled or rescheduled by a party or the party's attorney less than six (6) business days before the appointment date, except for good cause. Whenever the claims administrator, or if none the employer, or the injured worker, or either party's attorney, cancels an appointment scheduled by an evaluator, the cancellation shall be made in writing, state the reason for the cancellation and be served on the opposing party. Oral cancellations shall be followed with a written confirming letter that is faxed or mailed by first class U.S. mail within twenty four hours of the verbal cancellation and that complies with this section. An injured worker shall not be liable for any missed appointment fee whenever an appointment is cancelled for good cause. The Appeals Board shall retain jurisdiction to resolve disputes regarding whether an appointment cancellation by a party pursuant to this subdivision was for good cause.

(i) The date of cancellation shall be determined from the date of postmark, if mailed, or from the facsimile receipt date as shown on the recipient's fax copy.

NOTE: Form referred to above is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections , 133, 139.2 and 5307.3, Labor Code. Reference: Sections 4060, 4061, 4062, 4062.1, 4062.2 and 4067, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Amendment of subsections (a) and (c) filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Amendment of section heading, section and Note filed 1-13-2009; operative 2- 17-2009 (Register 2009, No. 3).

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§34.1. The Appointment Notification Form. [Repealed]

NOTE: Authority cited: Sections 139 and 139.2, Labor Code. Reference: Sections 139.2, 4061 and 4062, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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§35. Exchange of Information and Ex Parte Communications.

(a) The claims administrator, or if none the employer, shall provide, and the injured worker may provide, the following information to the evaluator, whether an AME, Agreed panel QME or QME:

(1) All records prepared or maintained by the employee's treating physician or physicians;

(2) Other medical records, including any previous treatment records or information, which are relevant to determination of the medical issue(s) in dispute;

(3) A letter outlining the issues that the evaluator is requested to address in the evaluation, which shall be served on the opposing party no less than 20 days in advance of the evaluation;

(4) Whenever the treating physician's recommended medical treatment is disputed, a copy of the treating physician's report recommending the medical treatment with all supporting documents, a copy of claims administrator's, or if none the employer's, decision to approve, delay, deny or modify the disputed treatment with the documents supporting the decision, and all other relevant communications about the disputed treatment exchanged during the utilization review process required by Labor Code section 4610;

(5) Non-medical records, including films and videotapes, which are relevant to determination of medical issue(s) in dispute, after compliance with subdivision 35(c) of Title 8 of the California Code of Regulations.

(b)(1) All communications by the parties with the evaluator shall be in writing and sent simultaneously to the opposing party when sent to the medical evaluator, except as otherwise provided in subdivisions (c), (k) and (l) of this section.

(2) Represented parties who have selected an Agreed Medical Evaluator or an Agreed Panel QME shall, as part of their agreement, agree on what information is to be provided to the AME or the Agreed Panel QME, respectively.

(c) At least twenty (20) days before the information is to be provided to the evaluator, the party providing such medical and non-medical reports and information shall serve it on the opposing party. Mental health records that are subject to the protections of Health and Safety Code section 123115(b) shall not be served directly on the injured employee, but may be provided to a designated health care provider as provided in section 123115(b)(2), and the injured employee shall be notified in writing of this option for each such record to be provided to the evaluator. In both unrepresented and represented cases the claims administrator shall attach a log to the front of the records and information being sent to the opposing party that identifies each record or other information to be sent to the evaluator and lists each item in the order it is attached to or appears on the log. In a represented case, the injured worker's attorney shall do the same for any records or other information to be sent to the evaluator directly from the attorney's office, if any. The claims administrator, or if none the employer, shall include a cover letter or other document when providing such information to the employee which shall clearly and conspicuously include the following language: "Please look carefully at the enclosed information. It may be used by the doctor who is evaluating your medical condition as it relates to your workers' compensation claim. If you do not want the doctor to see this information, you must let me know within 10 days."

(d) If the opposing party objects within 10 days to any non-medical records or information proposed to be sent to an evaluator, those records and that information shall not be provided to the evaluator unless so ordered by a Workers' Compensation Administrative Law Judge.

(e) In no event shall any party forward to the evaluator: (1) any medical/legal report which has been rejected by a party as untimely pursuant to Labor Code section 4062.5; (2) any evaluation or consulting report written by any physician other than a treating physician, the primary treating physician or secondary physician, or an evaluator through the medical-legal process in Labor Code sections 4060 through 4062, that addresses permanent impairment, permanent disability or apportionment under California workers' compensation laws, unless that physician's report has first been ruled admissible by a Workers' Compensation Administrative Law Judge; or (3) any medical report or record or other information or thing which has been stricken, or found inadequate or inadmissible by a Workers' Compensation Administrative Law Judge, or which otherwise has been deemed inadmissible to the evaluator as a matter of law.

(f) Either party may use discovery to establish the accuracy or authenticity of non-medical records or information prior to the evaluation.

(g) Copies of all records being sent to the evaluator shall be sent to all parties except as otherwise provided in section (d) and (e). Failure to do so shall constitute ex parte communication within the meaning of subdivision (k) below by the party transmitting the information to the evaluator.

(h) In the event that the unrepresented employee schedules an appointment within 20 days of receipt of the panel, the employer or if none, the claims administrator shall not be required to comply with the 20 day time frame for sending medical information in subsection (c) provided, however, that the unrepresented employee is served all non-medical information in subdivision (c) 20 days prior to the information being served on the QME so the employee has an opportunity to object to any non-medical information.

(i) In the event that a party fails to provide to the evaluator any relevant medical record which the evaluator deems necessary to perform a comprehensive medical-legal evaluation, the evaluator may contact the treating physician or other health care provider, to obtain such record(s). If the party fails to provide relevant medical records within 10 days after the date of the evaluation, and the evaluator is unable to obtain the records, the evaluator shall complete and serve the report to comply with the statutory time frames under section 38 of Title 8 of the California Code of Regulations. The evaluator shall note in the report that the records were not received within the required time period. Upon request by a party, or the Appeals Board, the evaluator shall complete a supplemental evaluation when the relevant medical records are received. For a supplemental report the evaluator need not conduct an additional physical examination of the employee if the evaluator believes a review of the additional records is sufficient.

(j) The evaluator and the employee's treating physician(s) may consult as necessary to produce a complete and accurate report. The evaluator shall note within the report new or additional information received from the treating physician.

(k) The Appeals Board shall retain jurisdiction in all cases to determine disputes arising from objections and whether ex parte contact in violation of Labor Code section 4062.3 or this section of Title 8 of the California Code of Regulations has occurred. If any party communicates with an evaluator in violation of Labor Code section 4062.3, the Medical Director shall provide the aggrieved party with a new panel in which to select a new QME or the aggrieved party may elect to proceed with the original evaluator. Oral or written communications by the employee, or if the employee is deceased by the employee's dependent, made in the course of the examination or made at the request of the evaluator in connection with the examination shall not provide grounds for a new evaluator unless the Appeals Board has made a specific finding of an impermissible ex parte communication.

(l) In claims involving a date of injury prior to 1/1/2005 where the injured worker is represented by an attorney and the parties have decided to each select a separate Qualified Medical Evaluator, the provisions of this section shall not apply to the communications between a party and the QME selected by that party.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4062.3, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. New subsection (c) and subsection relettering, amendment of newly designated subsections (d) and (e) and new subsection (f) filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

3. New subsection (b)(3) and amendment of subsection (e) filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

4. Amendment of section heading, section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§35.5. Compliance by AMEs and QMEs with Administrative Director Evaluation and Reporting Guidelines.

(a) Each evaluation examination and report completed pursuant to Labor Code sections 4060, 4061, 4062, 4062.1, 4062.2, 4064, 4067 or 5703.5 shall be performed in compliance with all appropriate evaluation procedures pursuant to this Chapter.

(b) Each reporting evaluator shall state in the body of the comprehensive medical-legal report the date the examination was completed and the street address at which the examination was performed. If the evaluator signs the report on any date other than the date the examination was completed, the evaluator shall enter the date the report is signed next to or near the signature on the report.

(c) The evaluator shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's appointment with the medical evaluator that are issues within the evaluator's scope of practice and areas of clinical competence. The reporting evaluator shall attempt to address each question raised by each party in the issue cover letter sent to the evaluator as provided in subdivision 35(a)(3).

(d) At the evaluator's earliest opportunity and no later than the date the report is served, the evaluator shall advise the parties in writing of any disputed medical issues outside of the evaluator's scope of practice and area of clinical competency in order that the parties may initiate the process for obtaining an additional evaluation pursuant to section 4062.1 or 4062.2 of the Labor Code and these regulations in another specialty. In the case of an Agreed Panel QME or a panel QME, the evaluator shall send a copy of the written notification provided to the parties to the Medical Director at the same time. However, only a party's request for an additional panel, with the evaluator's written notice under this section attached, or an order by a Workers' Compensation Administrative Law Judge, will be acted upon by the Medical Director to issue a new QME panel in another specialty in the claim.

(e) In the event a new injury or illness is claimed involving the same type of body part or body system and the parties are the same, or in the event either party objects to any new medical issue within the evaluator's scope of practice and clinical competence, the parties shall utilize to the extent possible the same evaluator who reported previously.

(f) Unless the Appeals Board or a Workers' Compensation Administrative Law Judge orders otherwise or the parties agree otherwise, whenever a party is legally entitled to depose the evaluator, the evaluator shall make himself or herself available for deposition within at least one hundred twenty (120) days of the notice of deposition and, upon the request of the unrepresented injured worker and whenever consistent with Labor Code section 5710, the deposition shall be held at the location at which the evaluation examination was performed, or at a facility or office chosen by the deposing party that is not more than 20 miles from the location of the evaluation examination.

(g) Whenever an Agreed Medical Evaluator or Qualified Medical Evaluator provides an opinion in a comprehensive medical/legal report on a disputed medical treatment issue, the evaluator's opinion shall be consistent with and apply the standards of evidence-based medicine set out in Division 1, Chapter 4.5, Subchapter 1, sections 9792.20 et seqof Title 8 of the California Code of Regulations (Medical Treatment Utilization Schedule). In the event the disputed medical treatment, condition or injury is not addressed by the Medical Treatment Utilization Schedule, the evaluator's medical opinion shall be consistent with and refer to other evidence-based medical treatment guidelines, peer reviewed studies and articles, if any, and otherwise shall explain the medical basis for the evaluator's reasoning and conclusions.

Note: Authority cited: Sections 133, 139.2, 4062.3 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064, 4067, 4604.5, 4628, 5703.5, 5307.27 and 5710, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

2. Amendment of section heading and section and newNote filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§36. Service of Comprehensive Medical-Legal Evaluation Reports by Medical Evaluators Including Reports Under Labor Code Section 4061.

(a) Whenever an injured worker is represented by an attorney, the evaluator shall serve each comprehensive medical-legal evaluation report, follow-up comprehensive medical-legal evaluation report and supplemental evaluation report on the injured worker, his or her attorney and on the claims administrator, or if none the employer, by completing QME Form 122 (AME or QME Declaration of Service of Medical-Legal Report Form)(See, 8 Cal. Code Regs. § 122) and attaching QME Form 122 to the report, unless section 36.5 of Title 8 of the California Code of Regulations applies. If applicable in a claim involving disputed injury to the psyche, the evaluator shall comply with the requirements of section 36.5 of Title 8 of the California Code of Regulations (Service of Comprehensive Medical-Legal Report in Claims of Injury to the Psyche)(See, 8 Cal. Code Regs. §§ 36.5, 120 and 121).

(b) Whenever an injured worker is not represented by an attorney, the Qualified Medical Evaluator shall serve each comprehensive medical-legal evaluation report, follow-up evaluation report or supplemental report that addresses only disputed issues outside of the scope of Labor Code section 4061, by completing the questions and declaration of service on the QME Form 111 (QME Findings Summary Form) (See, 8 Cal. Code Regs. § 111), and by serving the report with the QME Form 111 attached, on the injured worker and the claims administrator, or if none on the employer, unless section 36.5 of Title 8 of the California Code of Regulations applies. If applicable in a claim involving disputed injury to the psyche, the evaluator shall comply with the requirements of section 36.5 of Title 8 of the California Code of Regulations (Service of Comprehensive Medical-Legal Report in Claims of Injury to the Psyche)(See, 8 Cal. Code Regs. §§ 36.5, 120 and 121.)

(c) Whenever the evaluator is serving a medical-legal evaluation report that addresses or describes findings and conclusions pertaining to permanent impairment, permanent disability or apportionment of an unrepresented injured worker, the evaluator shall serve the evaluation report, the completed QME Form 111 (QME Findings Summary Form) (See, 8 Cal. Code Regs. § 111), DWC-AD Form 100 (DEU) (Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. §§ 10160 and 10161) and DWC-AD Form 101 (DEU) (Request for Summary Rating Determination of Qualified Medical Evaluator's Report)(See, 8 Cal. Code Regs. §§10160 and 10161), with the document cover sheet, DWC-CA form 10232.1 (see, 8 Cal. Code Regs. § 10232.1), and separator sheet, DWC-CA form 10232.2 (see, 8 Cal. Code Regs. § 10232.2), as required by Title 8, California Code of Regulations section 10160(d)(4), on the local DEU office, at the same time as serving the report, QME Form 111, DWC-AD Form 100 (DEU) and DWC-AD Form 101 (DEU) on the claims administrator, or if none the employer, and on the unrepresented employee within the time frames specified in section 38 of Title 8 of the California Code or Regulations, unless section 36.5 of Title 8 of the California Code of Regulations applies. If applicable, in cases involving disputed injury to the psyche, the evaluator shall follow the procedures described in section 36.5 of Title 8 of the California Code of Regulations (Service of Comprehensive Medical-Legal Report in Claims of Injury to the Psyche)(See, 8 Cal. Code Regs.§§ 36.5, 120 and 121).

(d) If an evaluation report is completed for an unrepresented employee, in which the QME determines that the employee's condition has not become permanent and stationary as of the date of the evaluation, the parties shall request any further evaluation from the same QME if the QME is currently an active QME and available at the time of the request for the additional evaluation. If the QME is unavailable, a new panel may be issued to resolve any disputed issue(s). If the evaluator is no longer a QME, he/she may issue a supplemental report as long as a face-to-face evaluation (as defined in section 49(b) of Title 8 of the California Code of Regulations) with the injured worker is not required. In no event shall a physician who is not a QME or no longer a QME perform a follow up evaluation on an unrepresented injured worker.

(e) After a Qualified Medical Evaluator has served a comprehensive medical-legal report that finds and describes permanent impairment, permanent disability or apportionment in the case of an unrepresented injured worker, the QME shall not issue any supplemental report on any of those issues in response to a party's request until after the Disability Evaluation Unit has issued an initial summary rating report, or unless the evaluator is otherwise directed to issue a supplemental report by the Disability Evaluation Unit, by the Administrative Director or by a Workers' Compensation Administrative Law Judge. A party wishing to request a supplemental report pursuant to subdivision 10160(f) of Title 8 of the California Code of Regulations, based on the party's objection to or need for clarification of the evaluator's discussion of permanent impairment, permanent disability or apportionment, may do so only by sending the detailed request, within the time limits of subdivision 10160(f), directly to the DEU office where the report was served by the evaluator and not to the evaluator until after the initial summary rating has been issued.

NOTE: Forms referred to above are available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 4060, 4061, 4062, 4062.1, 4062.2, 4064, 4067, 4600 and 4660-4664, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Amendment of section heading, section and Note filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Amendment of section heading, section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§36.1. The Qualified or Agreed Medical Evaluator's Findings Summary Form.

NOTE: Authority cited: Sections 139, 139.2, 4061 and 4062, Labor Code. Reference: Sections 139.2, 4061 and 4062, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Change without regulatory effect amending section filed 11-9-94 pursuant to section 100, title 1, California Code of Regulations (Register 94, No. 45).

3. Amendment of section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

4. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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New query

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§36.5. Service of Comprehensive Medical/Legal Report in Claims of Injury to the Psyche.

(a) For any evaluation involving a claimed or disputed injury to the psyche, the injured worker shall be advised by the evaluator that the employee's copy of the comprehensive medical-legal report, and any follow up or supplemental reports, from the evaluation may be served either directly on the injured worker or instead on a physician designated in writing by the injured worker prior to leaving the evaluator's office, for the purpose of reviewing and discussing the evaluation report with the injured worker. The evaluator shall explain that the designated physician may be but need not be the injured worker's primary treating physician in the workers' compensation claim and that the employer will be responsible for payment for one office visit with the designated physician for this purpose.

(b) Whenever injury to the psyche is claimed and in the course of the evaluation, the evaluator makes a determination pursuant to Health and Safety Code section 123115(b) that there is a substantial risk of significant adverse or detrimental medical consequences to the injured worker from seeing or receiving a copy of part or all of evaluation report which is a mental health record, the evaluator shall do all of the following:

(1) Complete QME Form 121 (Declaration Regarding Protection of Mental Health Record);

(2) Advise the injured worker that the determination under Health and Safety Code 123115(b) has been made regarding the evaluation report as a mental health record and that the evaluator only may serve the injured worker's copy of the evaluation report on a person who is a licensed physician, as defined in Labor Code section 3209.3, whose name the injured worker may designate in writing prior to leaving the evaluator's office, or on the employee's attorney, if any;

(3) Permit inspection and copying of the mental health record(s) subject to the Health and Safety Code section 123115(b) determination, only by a licensed physician as defined in Labor Code section 3209.3 or another health care provider as defined in Health and Safety Code section 123105(a);

(4) Complete the QME Form 121 and enter the name and address of the physician designated in writing by the injured worker on this form;

(5) Attach a completed copy of QME Form 121 (Declaration Regarding Protection of Mental Health Record) to the copy of the evaluation report in the injured worker's medical or medical-legal file;

(6) Serve the completed comprehensive medical-legal evaluation report, follow-up medical-legal report or supplemental medical-legal report(s) subject to the provisions of this section, with the completed QME Form 121 (Declaration Regarding Protection of Mental Health Record) attached, on the licensed physician designated by the injured worker on QME Form 121, and on the claims administrator, and on each party's attorney, if any, as provided in section 36, and within the time periods in section 38, of Title 8 of the California Code of Regulations. In the event the injured worker designates a physician on QME Form 121 other than the current primary treating physician in his or her workers' compensation claim, the evaluator shall also serve a copy of the report with the QME Form 121 attached on the primary treating physician;

(7) Whenever the report addresses any permanent impairment, permanent disability or apportionment and the injured worker is not represented by an attorney, a copy of the report with the completed QME Form 121 attached shall also be served on the appropriate office of the Disability Evaluation Unit, along with the QME Form 111 (QME's Findings Summary Form), and DWC-AD form 100 (DEU) (Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. §§ 10160 and 10161) and DWC-AD form 101 (DEU) (Request for Summary Rating Determination of Qualified Medical Evaluator's Report)(See, 8 Cal. Code Regs. §§10160 and 10161), with the document cover sheet, DWC-CA form 10232.1 (see, 8 Cal. Code Regs. § 10232.1), and separator sheet, DWC-CA form 10232.2 (see, 8 Cal. Code Regs. § 10232.2), as required by Title 8, California Code of Regulations section 10160(d)(4);

(8) Whenever the report addresses permanent impairment, permanent disability or apportionment and the injured worker is represented by an attorney, a copy of the report with the completed QME Form 121 attached shall be served with QME Form 122 (AME or QME Declaration of Service of Medical-Legal Report) on the physician designated by the injured worker, the injured worker's attorney and on the claims administrator's attorney, or if none on the claims administrator.

(c) "Mental health record" for the purposes of this subdivision means a medical treatment or evaluation record created by or received and reviewed by a licensed physician, as defined in Labor Code section 3209.3, in the course of treating or evaluating the injured worker in a workers' compensation claim, and includes for the purposes of this subdivision but is not limited to, treatment records and comprehensive medical-legal reports.

(d) Upon serving the employee's copy of the medical-legal report in compliance with subdivisions 36.5(b)(6), 36.5(b)(7) or 36.5(b)(8) of Title 8 of the California Code of Regulations on the physician designated by the employee on the QME Form 121 (Declaration Regarding Protection of Mental Health Record), the evaluator's obligation to serve the report on the injured worker under Labor Code sections 139.2(j)(1) and 4061(c), and section 36 of Title 8 of the California Code of Regulation, shall be deemed satisfied.

(e) Mental health records subject to a determination under Health and Safety Code section 123115(b) and this subdivision shall be kept confidential by the claims administrator and all parties' attorneys in the case unless ordered otherwise by a Workers' Compensation Administrative Law Judge. Whenever such a mental health record is filed by a party at the Workers' Compensation Appeals Board, the party filing such a record shall request and obtain a protective order from a Workers' Compensation Administrative Law Judge that shall specify in what manner the mental health record may be inspected, copied and entered into evidence.

(f) Whenever the injured worker advises the evaluator that he or she prefers to have the evaluation report served on a designated physician as provided in subdivision 36.5(b) above, and the evaluator does not make a determination pursuant to Health and Safety Code section 123115(b), the evaluator shall provide QME Form 120 (Voluntary Directive for Alternate Service of Medical-Legal Report) (See, 8 Cal. Code Regs. § 120) to the injured worker and shall request the injured worker to complete the form before leaving the evaluator's office.

(g) Upon receipt by the evaluator of a QME Form 120 completed by the injured worker, the evaluator shall attach the original executed QME Form 120 to the original medical-legal report for service on the claims administrator, or if none on the employer. The evaluator shall serve the evaluation report with QME Form 120 attached by completing the questions and the declaration of proof of service on QME Form 111 (Qualified Medical Evaluator's Findings Summary Form) (See, 8 Cal. Code Regs. § 111). In the case of an unrepresented injured worker, the evaluator shall serve the report with the required forms as provided in subdivision 36.5(b)(7) of Title 8 of the California Code of Regulations. In the case of a represented injured worker, the evaluator shall serve the report with QME Form 120 attached, by completing the declaration of service on QME Form 122 (AME or QME Declaration of Service of Medical-Legal Report)(See, 8 Cal. Code § 122) and serving it with the report.

(h) Whenever an evaluation report is being served on a designated physician with QME Form 120 (Voluntary Directive for Alternate Service of Medical-Legal Report) (See, 8 Cal. Code Regs. § 120), the evaluator shall serve two copies of the medical-legal report with the QME Form 120 attached on the physician designated on the form by the injured worker, at the same time as serving the copies of the medical-legal report on the claims administrator, or if none on the employer, and on the injured worker's attorney if any. Service of a medical-legal report by an evaluator in compliance with this subdivision shall satisfy the evaluator's obligation to serve a copy of the report on the employee under Labor Code sections 139.2(j)(1) and 4061(c,) and section 36 of Title 8 of the California Code of Regulations.

(i) The physician designated by the injured worker in writing and listed on QME Form 120 or QME Form 121 shall not be limited to the primary treating physician in the disputed workers' compensation claim. As an additional medical treatment expense incurred in the claim within the meaning of section 4600 of the Labor Code, the claims administrator, or if none the employer, shall reimburse the physician designated by the injured worker and listed on either the QME Form 121 (Declaration Regarding Protection of Mental Health Record) or the QME Form 120 (Voluntary Directive for Alternate Service of Medical-Legal Evaluation Report on Disputed Injury to the Psyche), for one office visit, when used, for the purpose of reviewing and discussing the evaluator's report with injured worker, at the applicable rate under section 9789.11 (Physician Services Rendered on or After July 1, 2004) of Title 8 of the California Code of Regulations for an office visit and may include, as appropriate, record review, any necessary face-to-face time during the visit in excess of that specified in the applicable CPT office visit code, and charges, for time required to prepare a treatment report pertaining to the office visit, if necessary.

(j)Whenever the comprehensive medical-legal report is served by the evaluator on a physician pursuant to subdivision 36.5(f) with the QME Form 120 (Voluntary Directive for Alternate Service of Medical-Legal Report on Disputed Injury to the Psyche) attached, one of the two copies of the medical-legal report served on the designated physician shall be provided to the injured worker by the designated physician during the office visit.

(k) In the event the injured worker refuses or fails to designate a physician in writing to be listed on either QME Form 120 or QME Form 121, the evaluator shall serve the report as appropriate under section 36 or section 36.5, and within the time periods under section 38, of Title 8 of the California Code of Regulations, except that the injured worker's copy of the report which is subject to a finding under Health and Safety Code § 123115(b) shall then be served only on the injured worker's attorney, if represented, or if not represented on the injured worker's primary treating physician.

NOTE: Forms referred to above are available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 56-56.37, Civil Code; Sections 4060, 4061, 4062, 4062.1, 4062.2, 4064, 4067, 4600 and 4660-4664, Labor Code; Section 123115(b), Health and Safety Code.

HISTORY

1. New section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§37. [Reserved]

Pursuant to Labor Code Sections 4061.5 and 139(e)(9), this form may be used by the treating physician primarily responsible for managing the care of the injured worker, or the physician designated by that physician, when rendering opinions on all medical issues necessary to determine eligibility for compensation. The Treating Physician's Determination of Medical Issues Form (Treating Physician's Form) is as follows:

NOTE: Sections 139, 4061 and 4061.5, Labor Code. Reference: Sections 139(e)(9), 4061 and 4061.5, Labor Code.

HISTORY

1. New section and forms filed 5-17-95; operative 5-24-95 pursuant to Government Code section 11343.4(d) (Register 95, No. 20).

Treating Physician's Determination of Medical Issues Form (.pdf format, 20K)

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§38. Medical Evaluation Time Frames; Extensions for QMEs and AMEs.

(a) The time frame for an initial or a follow-up comprehensive medical-legal evaluation report to be prepared and submitted shall not exceed thirty (30) days after the QME, Agreed Panel QME or AME has seen the employee or otherwise commenced the comprehensive medical-legal evaluation procedure. If an evaluator fails to prepare and serve the initial or follow-up comprehensive medical-legal evaluation report within thirty (30) days and the evaluator has failed to obtain approval from the Medical Director for an extension of time pursuant to this section, the employee or the employer may request a QME replacement pursuant to section 31.5 of Title 8 of the California Code of Regulations. Neither the employee nor the employer shall have any liability for payment for the medical evaluation which was not completed within the timeframes required under this section unless the employee and the employer each waive the right to a new evaluation and elect to accept the original evaluation, in writing or by signing and returning to the Medical Director either QME Form 113 (Notice of Denial of Request For Time Extension) or QME Form 116 (Notice of Late QME/AME Report - No Extension Requested) (See, 8 Cal. Code Regs. §§ 113 and 116).

(b) All requests by an evaluator for extensions of time shall be made on form 112 (QME/AME Time Frame Extension Request) (See, 8 Cal. Code Regs. § 112). If the evaluation will not be completed on the original due date, the evaluator may request an extension from the Medical Director, not to exceed an additional 30 days. An extension of the time for completing the report shall be approved, as follows:

(1) When the evaluator has not received test results or the report of a consulting physician, necessary to address all disputed medical issues in time to meet the initial 30-day deadline, an extension of up to thirty (30) days shall be granted;

(2) When the evaluator has good cause, as defined in Labor Code section 139.2(j)(1)(B), an extension of fifteen (15) days shall be granted.

(c) Not later than 5 days before the initial 30-day period to complete and serve the report expires, the evaluator shall notify the Medical Director, the employee and the claims administrator, or if none, the employer, of the request for an extension by use of QME Form 112 (QME/AME Time Extension Request) (See, 8 Cal. Code Regs. § 112).

(d) The Medical Director shall notify the requesting evaluator and the parties of the decision on the extension request by completion of the box at the bottom of QME Form 112 (QME/AME Time Frame Extension Request)(See, 8 Cal. Code Regs. § 112). In the event that a request for an extension of time is denied, the Medical Director shall also send the parties QME Form 113 (Notice of Denial of Request for Time Extension)(See, 8 Cal. Code Regs. § 113) to be used

by each party to state whether the party wishes to request a new evaluator or to accept the late report of the original evaluator.

(e) Whenever the Medical Director becomes aware that the report of a Qualified Medical Evaluator or an Agreed Medical Evaluator has not been completed within the required time under section 38 and no extension of time was requested by the evaluator, the Medical Director shall send the parties a Notice of Late QME/AME Report - No Extension Requested (QME Form 116) (See, 8 Cal. Code Regs. § 116). Each party shall complete the form and return it to the Medical Director in order to indicate whether or not the party wishes to accept the late report.

(f) Good cause, as defined in Labor Code section 139.2(j)(1)(B) and section 38(b)(2) of Title 8 of the California Code of Regulations, means:

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

(2) death in the evaluator's family;

(3) natural disasters or other community catastrophes that interrupt the operation of the evaluator's office operations;

(g) Extensions shall not be granted because relevant medical information/records (including Disability Evaluation Form 101 (Request for Summary Determination of Qualified Medical Evaluator's Report) (See, 8 Cal. Code Regs. § 10161)) have not been received. The evaluator shall complete the report based on the information available and state that the opinions and/or conclusions may or may not change after review of the relevant medical information/records.

(h) The time frame for supplemental reports shall be no more than sixty (60) days from the date of a written or electronically transmitted request to the physician by a party. The request for a supplemental report shall be accompanied by any new medical records that were unavailable to the evaluator at the time of the original evaluation and which were properly served on the opposing party as required by Labor Code section 4062.3. An extension of the sixty (60) day time frame for completing the supplemental report, of no more than thirty (30) days, may be agreed to by the parties without the need to request an extension from the Medical Director.

(i) Evaluators requesting time extensions will be monitored and advised by the Medical Director when such a request appears unreasonable or excessive. Failure to comply with this section may constitute grounds for denial of the QME's request for reappointment pursuant to section 51 of Title 8 of the California Code of Regulations.

NOTE: Forms referred to above are available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 133, 139.2(j)(1), 4061, 4062 and 5307.3, Labor Code. Reference: Sections 139.2, 4061, 4062, 4062.1, 4062.2, 4062.5, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Amendment of subsections (a) and (b), new subsections (c)-(c)(3) and subsection relettering, and amendment of newly designated subsection (d) filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

3. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

4. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§38.1. The QME and AME Time Frame Extension Request Form. [Repealed]

NOTE: Authority cited: Sections 139 and 139.2, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062 and 4062.5, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Change without regulatory effect amending form filed 4-2-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 14).

3. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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§38.2. "The Time Extension Approval" Form. [Repealed]

NOTE: Authority cited: Sections 139 and 139.2, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062 and 4062.5, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Change without regulatory effect amending section filed 3-28-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 13).

3. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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§38.3. The "Denial of Time Extension" Form. [Repealed]

NOTE: Authority cited: Sections 139 and 139.2, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062 and 4062.5, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Amendment of section heading and repealer and new section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

3. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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§38.4. TThe "Notice of Late QME Report" Form. [Repealed]

NOTE: Authority cited: Sections 139 and 139.2, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062 and 4062.5, Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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§39. Destruction of Records by the Medical Director.

The Medical Director may destroy any forms filed pursuant to these regulations five years after the date of receipt, provided that the completed "Application for Appointment as Qualified Medical Evaluator" form shall be preserved for each QME during the period(s) of his or her appointment as a QME. The "Request for Qualified Medical Evaluator" forms may be destroyed by the Medical Director two years after the date of receipt.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061 and 4062, Labor Code; and Section 14755, Government Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Amendment of section heading, section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§39.5. Retention of Records by QMEs.

(a) All QMEs shall retain a copy of all comprehensive medical-legal reports completed by the QME for a period of five years from the date of each evaluation report. A QME may satisfy this requirement by retaining only an electronic copy of the report, as long as the electronic copy retained is a true and correct copy of the original, showing the QME signature, that was served on the parties. Upon written request, a QME is required to return original radiological films, imaging studies and original medical records to the person who supplied the original records to the QME or to the injured worker.

(b) An evaluator shall submit all comprehensive medical/legal reports performed as a QME under this article to the Medical Director upon request for a review by the Medical Director. Failure to submit evaluations upon request by the Medical Director may constitute grounds for disciplinary action pursuant to Section 60.

Note: Authority cited: Sections 133, 139.2(j)(1) and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4062.5, Labor Code; and Section 14755, Government Code.

HISTORY

1. New section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

2. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Amendment of section heading, section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§40. Disclosure Requirements: Injured Workers.

(a) An evaluator selected from a QME panel shall advise an injured worker prior to or at the time of the actual evaluation of the following:

(1) That he or she is entitled to ask the evaluator and the evaluator shall promptly answer questions about any matter concerning the evaluation process in which the QME and the injured worker are involved;

(2) That subject to section 41(g), the injured worker may discontinue the evaluation based on good cause. Good cause includes: (A) discriminatory conduct by the evaluator towards the worker based on race, sex, national origin, religion, or sexual preference, (B) abusive, hostile or rude behavior including behavior that clearly demonstrates a bias against injured workers, and (C) instances where the evaluator requests the worker to submit to an unnecessary exam or procedure.

(b) When required as a condition of probation by the Administrative Director or his/her licensing authority, the QME shall disclose his/her probationary status. The QME shall be entitled to explain any circumstances surrounding the probation. If at that time, the injured worker declines to proceed with the evaluation, such termination shall be considered by the Administrative Director to have occurred for good cause.

(c) If the injured worker declines to ask any questions relating to the evaluation procedure as set forth in section 40(a), and does not otherwise object on the grounds of good cause to the exam proceedings under section 41(a) during the exam itself, the injured worker shall have no right to object to the QME comprehensive medical-legal evaluation based on a violation of this section.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2 and 4067, Labor Code.

HISTORY

1. New article 4 heading and section filed 4-11-95; operative 5-11-95 (Register 95, No. 15).

2. Amendment of article 4 heading filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Amendment of section heading, section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§41. Ethical Requirements.

(a) All QMEs, regardless of whether the injured worker is represented by an attorney, shall:

(1) Maintain a clean, professional physician's office (as defined in section 1(y) at all times which shall contain functioning medical instruments and equipment appropriate to conducting the evaluation within the physician's scope of practice and a functioning business office phone with the phone number listed with the Medical Director for that location which a party may use to schedule an examination or to handle other matters related to a comprehensive medical/legal evaluation.

(2) Schedule all appointments for comprehensive medical-legal evaluations without regard to whether a worker is unrepresented or represented by an attorney. A QME shall not refuse to schedule an appointment with an injured worker solely because the worker is not represented by an attorney or because a promise to reimburse or reimbursement is not made prior to the evaluation.

(3) Not request the employee to submit to an unnecessary exam or procedure.

(4) Refrain from treating or soliciting to provide medical treatment, medical supplies or medical devices to the injured worker.

(5) Communicate with the injured worker in a respectful, courteous and professional manner.

(6) Refrain from violating section 41.5 of Title 8 of the California Code of Regulations.

(7) Refrain from unilaterally rescheduling a panel QME examination more than two times in the same case.

(8) Refrain from cancelling a QME examination less than six (6) business days from the date the exam is scheduled without good cause and without providing a new examination date within thirty (30) calendar days of the date of

cancellation.

(b) Evaluators selected from a QME panel provided by the Administrative Director shall not engage in ex parte communication in violation of Labor Code section 4062.3.

(c) All QMEs, regardless of whether the injured worker is represented by an attorney, shall with respect to his or her comprehensive medical-legal evaluation:

(1) Refuse any compensation from any source contingent upon writing an opinion that in any way could be construed as unfavorable to a party to the case.

(2) Review all available relevant medical and non-medical records and/or facts necessary for an accurate and objective assessment of the contested medical issues in an injured worker's case before generating a written report. The report must list and summarize all medical and non-medical records reviewed as part of the evaluation.

(3) Render expert opinions or conclusions without regard to an injured worker's race, sex, national origin, religion or sexual preference.

(4) Render expert opinions or conclusions only on issues which the evaluator has adequate qualifications, education, and training. All conclusions shall be based on the facts and on the evaluator's training and specialty-based knowledge and shall be without bias either for or against the injured worker or the claims administrator, or if none the employer.

(5) Present a report that addresses all relevant and contested medical issues as presented on one or more claim forms, is ratable by the DEU, if applicable, and complies with all relevant guidelines of the Administrative Director.

(6) Date the report on the date it is completed and ready for signature and service on the parties. No report shall be dated on the date of the evaluation examination unless the full written text of the report is completed and ready for signature and service on that same date.

(7) Write all portions of the report that contain discussion of medical issues, medical research used as the basis for medical determinations, and medical conclusions made by the evaluator. In the event more than one evaluator signs a single report, each signing physician shall clearly state those parts of the employee evaluation examination performed and the portions of the report discussion and conclusion drafted by the signing evaluator. Where a consultation report is obtained by an evaluator from a physician in a different specialty, the consultation report shall be incorporated by reference into the final report and appended to the referring QME's report.

(8) Serve the report as provided in these regulations at the same time on the employee and the claims administrator, or if none the employer, and on each of their attorneys, respectively.

(d) All aspects of all physical and/or psychological comprehensive medical-legal evaluations, including history taking, shall be directly related to contested medical issues as presented by any party or addressed in the reports of treating physician(s). No evaluator shall engage in any physical contact with the injured worker which is unnecessary to complete the examination.

(e) No physician certified by the Administrative Director as a QME, or his or her agent, shall contact an evaluator for the purpose of influencing that evaluator's opinions or conclusions in any comprehensive medical-legal evaluation or report.

(f) No evaluator shall schedule appointments to the extent that any injured worker will be required to wait for more than one hour at the evaluator's office prior to being seen for the previously agreed upon appointment time for an evaluation. An injured worker who is not seen by the evaluator within one hour may terminate the exam and request a replacement evaluator from the Administrative Director. No party shall be liable for the terminated exam. The evaluator may explain any reasons for the delay to the injured worker and, provided both parties agree, the evaluation may proceed or be rescheduled for a later date. If the evaluation is rescheduled, the evaluator shall provide notice of the new date of the evaluation to the parties within 5 business days after rescheduling the appointment.

(g) If the injured worker terminates the examination process based on an alleged violation of section 35(k), 40, 41(a) or 41.5 of Title 8 of the California Code of Regulations, and the Appeals Board later determines that good cause did not exist for the termination, the cost of the evaluation shall be deducted from the injured worker's award. A violation of section 40 or of any part of section 41(a) or 41.5 by the evaluator shall constitute good cause for purposes of an Appeals Board determination. No party shall be liable for any cost for medical reports or medical services delivered as a result of an exam terminated for good cause.

(h) Nothing in this section shall require an evaluator to undertake or continue a comprehensive medical-legal evaluation where the injured worker or his/her representative uses abusive language towards the evaluator or evaluator's staff or deliberately attempts to disrupt the operation of the evaluator's office in any way. The evaluator shall state under penalty of perjury, the facts supporting the termination of the evaluation process. Upon request, the Medical Director shall investigate the facts and make a final determination of the issue(s).

(i) Nothing in this section shall require an evaluator selected from a panel to undertake or continue a comprehensive medical-legal evaluation where the injured worker is intoxicated or under the influence of any medication which impairs the injured worker's ability to participate in the evaluation process. The evaluator shall state under penalty of perjury, the facts supporting the termination of the evaluation process. Upon request, the Medical Director shall investigate the facts and make a final determination of the issue(s).

Note: Authority cited: Sections 133, 139.2, 5307.3 and 5307.6, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4062.3, 4062.5, 4067 and 4628, Labor Code.

HISTORY

1. New section filed 4-11-95; operative 5-11-95 (Register 95, No. 15).

2. New subsection (b), subsection relettering, and amendment of redesignated subsection (b)(1) filed 7-18-95 as an emergency; operative 7-18-95 (Register 95, No. 29). A Certificate of Compliance must be transmitted to OAL by 11-15-95 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 7-18-95 order including amendment of subsection (b), deletion of subsection (b)(1) designator, and amendment of Notetransmitted to OAL 11-14-95 and filed 12-21-95 (Register 95, No. 51).

4. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

5. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§41.5. Conflicts of Interest by Medical Evaluators.

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a) An evaluator shall 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 the Labor Code or the regulations of the Administrative Director (Title 8 of the California Code of Regulations, Chapters 1 through 1.8, section 1 et seq) or of the Workers' Compensation Appeals Board (Title 8 of the California Code of Regulations, Chapters 1.9, sections 10600 through 10727) .

(b) A conflict with the duties of an evaluator as used in Labor Code section 139.2(o) means having a disqualifying conflict of interest with one or more of the persons or entities described in subdivision (c) and failing to disclose the fact of the conflict.

(c) The persons or entities with whom a disqualifying conflict of interest can exist are:

(1) The injured worker, or his or her attorney;

(2) The employer, or the employer's attorney;

(3) The claims adjuster or insurer or third party administrator, or their attorney, respectively;

(4) Any primary treating physician or secondary physician for the employee, if the treatment provided by that physician is disputed in the case;

(5) The utilization review physician reviewer or expert reviewer, or utilization review organization, only if the opinion of that reviewer or that utilization review organization is disputed in the case;

(6) The surgical center in which the injured worker had, or is proposed to be used to have, surgery, only if the need for surgery is disputed in the case.

(7) Other purveyor of medical goods or medical services, only if the medical necessity for using such goods or

services is in dispute in the case.

(d) "Disqualifying Conflict of Interest" means the evaluator has any of the following relationships or interests with a person or entity listed in subdivision 41.5(c):

(1) A familial relationship of parent, child, grandparent, grandchild, sibling, uncle, aunt, nephew, niece, spouse, financee or cohabitant;

(2) A significant disqualifying financial interest, as defined below, including:

(A) Employment or a promise of employment;

(B) An interest of five (5) % or more in the fair market value of any form of business entity involved in workers' compensation matters, or of private real property or personal property, or in a leasehold interest;

(C) Five (5) % or more of the evaluator's income is received from direct referrals by or from one or more contracts with a person or entity listed in subdivision 41.5(c), except that contracts for participation in a Medical Provider Network as defined under Labor Code section 4616 et seq shall be excluded;

(D) A financial interest as defined in Labor Code section 139.3 that would preclude referral by the evaluator to such a person or entity;

(E) A financial interest as defined under the Physician Ownership and Referral Act of 1993 (PORA) set out in Business and Professions Code sections 650.01 and 650.02 that would preclude referral by the evaluator to such a person or entity.

(3) A professional affiliation which means the evaluator performs services in the same medical group or other business entity comprised of medical evaluators who specialize in workers' compensation medical-legal evaluations;

(4) Any other relationship or interest not addressed by subdivisions (d)(1) through (d)(3) which would cause a person aware of the facts to reasonably entertain a doubt that the evaluator would be able to act with integrity and impartiality.

(e) An Agreed Medical Evaluator or a Qualified Medical Evaluator may disqualify himself or herself on the basis of a conflict of interest pursuant to this section whenever the evaluator has a relationship with a person or entity in a specific case, including doctor-patient, familial, financial or professional, that causes the evaluator to decide it would be unethical to perform a comprehensive medical-legal evaluation examination or to write a report in the case.

(f) An Agreed Medical Evaluator or Qualified Medical Evaluator who knows, or should know, that he or she has a disqualifying conflict of interest with any person or entity listed in subdivision 41.5(c), that also is involved in the specific workers' compensation claim identified to the evaluator, shall send written notification to the injured worker and the claims administrator, or if none the employer, or their respective attorneys if any, within five (5) business days

of the evaluator becoming aware of the conflict. The written notice shall include, at a minimum: 1) disclosure that a disqualifying conflict of interest exists; 2) the person or entity with whom the conflict arises; and 3) the category of conflict, such as familial, significant financial, or other type of ethical conflict. Whenever the evaluator declines to perform an evaluation due to disqualifying himself or herself pursuant to subdivision 41.5(e), the parties shall be entitled to a replacement QME or, in represented cases a replacement panel pursuant to section 31.5 of Title 8 of the California Code of Regulations. Whenever the evaluator notifies the parties of a conflict without stating that he or she declines to perform the evaluation, the parties shall follow the procedures set out in section 41.6 of Title 8 of the California Code of Regulations. In any case in which the injured worker is not represented by an attorney, the evaluator shall fax a copy of the notice of conflict to the Medical Unit of the Division of Workers' Compensation at the same time it is sent to the parties.

(g) Any injured worker or claims administrator or if none the employer, including his or her attorney respectively, who knows of, or becomes aware of, a potential disqualifying conflict of interest, as defined under this section, with a specific evaluator selected to perform a comprehensive medical/legal examination and report or a follow up examination and report, shall notify the selected evaluator in writing at the earliest opportunity and no later than within five (5) business days of becoming aware of the potential conflict, to enable the evaluator to determine whether the disqualifying conflict exists. The notice shall include the person with whom the alleged conflict exists and the nature of the conflict. A copy of this notice shall be served on the opposing party at the same time as it is sent to the evaluator. The evaluator shall review the information provided and advise the parties in writing within five (5) business days of receipt of the notice whether the evaluator has a conflict of interest as specified in this section.

Note: Authority cited: Sections 133, 139.2(o) and 5307.3, Labor Code. Reference: Sections 139.2 and 139.3, Labor Code; and Sections 650.01 and 650.02, Business and Professions Code.

HISTORY

1. New section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§41.6. Procedures After Notice of Conflict of Interest and Waivers of Conflicts of Interest of an Evaluator.

(a) Whenever an Agreed or Qualified Medical Evaluator notifies the parties that a disqualifying conflict of interest exists, and even if it arises after the evaluator has performed an initial or follow up comprehensive medical-legal evaluation, the parties shall use the following procedures.

(b) An evaluator shall proceed with any scheduled evaluation involving a physical examination or supplemental report in the case, unless either the evaluator declines to proceed due to disqualifying himself or herself pursuant to section 41.5(e) of Title 8 of the California Code of Regulations or unless, pursuant to this section, the injured worker or the claims administrator is entitled to a replacement QME.

(c) Within five (5) business days of receipt of the evaluator's notice of conflict:

(1) If the injured worker is not represented by an attorney, the parties shall obtain a new evaluator by following the procedure provided under section 31.5 of Title 8 of the California Code of Regulations and a replacement QME, or when necessary replacement QME panel, shall be issued.

(2) If the injured worker is represented by an attorney, each party shall notify the evaluator and the opposing party in writing of the party's decision either to waive the conflict or to object to the evaluator on the basis of the evaluator's conflict. Whenever either party objects to the evaluator due to a conflict, the parties shall obtain a new evaluator by following the procedures provided in Labor Code section 4062.2 and section 31.5 of Title 8 of the California Code of Regulations.

(3) In the event the parties in a represented case wish to waive a conflict of interest, any such waiver shall be valid only if the general nature of the conflict of interest is disclosed in writing and on the same document, or duplicate copies of the same document, each party has signed a statement indicating that the signing party understands that the evaluator has a conflict of interest, the party understands the nature of the conflict, and the party wishes to waive the opportunity to obtain another evaluator. The signature of an attorney shall have the same effect as the signature of the party represented by the attorney, if a copy of the document signed by the attorney is served on the represented party by the attorney or by any other party or attorney. It shall be the duty of the attorney to serve a copy of the signed document on the party-client.

(d) Any dispute over whether a conflict of interest of an evaluator may affect the integrity and impartiality of the

evaluator with respect to an evaluation report or supplemental report, and any dispute over waiver of an evaluator's conflict under this section, shall be determined by a Workers' Compensation Administrative Law Judge.

Note: Authority cited: Sections 133, 139.2(o) and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§42. Disciplinary Proceedings. [Repealed]

NOTE: Authority cited: Sections 139.2 and 5307.3, Labor Code; Section 11370 et seq., Government Code; and Section 11500 et seq., Government Code. Reference: Sections 139, 139.2, 4060, 4061 and 4062, Labor Code

HISTORY

1. New section filed 4-11-95; operative 5-11-95 (Register 95, No. 15).

2. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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§43. Method of Measurement of Psychiatric Disability.

(a) For all claims arising before January 1, 2005, not subject to section 43(b), the method of measuring the psychiatric elements of a disability shall be as set forth below in the "Psychiatric Protocols" as adopted by the Industrial Medical Council on July 16, 1992, and amended on March 18 and October 25, 1993. The full text of this document is available at no charge on the web at www.dir.ca.gov/IMC/guidelines.html or by calling the Medical Unit at 1-800-794-6900.

(b) For all claims having dates of injury on or after January 1, 2005, and for those compensable claims arising before January 1, 2005, where there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the claims administrator, or if none the employer, is not required to provide the notice required by section 4061 to the injured worker, the method of evaluating the psychiatric elements of impairment shall include describing the employee's symptoms, social, occupational and, if relevant, school functioning, and describing the rationale for the evaluator's assignment to a level of impairment as published in the Permanent Disability Rating Schedule adopted by the Administrative Director on or after January 2005 pursuant to section 9805 of Title 8 of the California Code of Regulations.

Note: Authority cited: Sections 133, 139.2(j)(4) and 5307.3, Labor Code. Reference: Sections 139.2(j)(4), 4060, 4061, 4062, 4062.1, 4062.2, 4067, 4628 and 4660, Labor Code, and Section 9805 of Title 8 of the California Code of Regulations.

HISTORY

1. New section filed 12-7-93; operative 1-6-94 (Register 93, No. 50).

2. Change without regulatory effect amending section filed 3-15-94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No.11).

3. Change without regulatory effect amending section filed 9-7-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No.36).

4. Change without regulatory effect amending section filed 7-12-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 28). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

5. Amendment of section heading, section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§44. Method of Evaluation of Pulmonary Disability.

(a) For all claims arising before January 1, 2005, not subject to section 44(b), the method of measuring the pulmonary elements of disability shall be as set forth below in the "Guidelines for Evaluation of Pulmonary Disability" as adopted by the Industrial Medical Council on December 4, 1997. The full text of this document is available at no charge on the web at www.dir.ca.gov/IMC/guidelines.html or by calling the Medical Unit at 1-800-794- 6900.

(b) For all claims having dates of injury on or after January 1, 2005, and for those compensable claims arising before January 1, 2005, where there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the claims administrator, or if none the employer, is not required to provide the notice required by section 4061 to the injured worker, the method of measuring the pulmonary elements of impairment shall be as described in the American Medical Association, Guides to the Evaluation of Permanent Impairment [Fifth Edition] (AMA Guides). Permanent disability shall be described by applying the provisions of the Permanent Disability Rating Schedule adopted by the Administrative Director pursuant to section 9805 of Title 8 of the California Code of Regulations.

Note: Authority cited: Section 133, 39.2(j)(2) and 5307.3 Labor Code. Reference: Sections 139.2(j)(2), 4060, 4061, 4062, 4062.1, 4062.2, 4067, 4628 and 4660, Labor Code.

HISTORY

1. New section filed 5-23-94; operative 6-22-94 (Register 94, No. 21).

2. Amendment of section and Note filed 6-19-98; operative 7-19-98 (Register 98, No. 25).

3. Change without regulatory effect amending section filed 7-12-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 28). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

4. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register

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§45. Method of Evaluation of Cardiac Disability.

(a) For all claims arising before January 1, 2005, not subject to section 45(b), the method of measuring the cardiac elements of disability shall be set forth below in the "Guidelines for Evaluation of Cardiac Disability" as adopted by the Industrial Medical Council on December 4, 1997 and updated on July 19, 1998. The full text of this document is available at no charge on the web at www.dir.ca.gov/IMC/guidelines.html or by calling the Medical Unit at 1-800-794-6900.

(b) For all claims having dates of injury on or after January 1, 2005, and for those compensable claims arising before January 1, 2005, where there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the claims administrator, or if none the employer, is not required to provide the notice required by section 4061 to the injured worker, the method of measuring the cardiac elements of impairment shall be as described in the American Medical Association, Guides to the Evaluation of Permanent Impairment [Fifth Edition] (AMA Guides). Permanent disability shall be described by applying the provisions of the Permanent Disability Rating Schedule adopted by the Administrative Director pursuant to section 9805 of Title 8 of the California Code of Regulations.

Note: Authority cited: Section 133, 139.2(j)(2) and 5307.3, Labor Code. Reference: Sections 139.2(j)(2), 4060, 4061, 4062, 4062.1, 4062.2, 4067, 4628 and 4660, Labor Code.

HISTORY

1. New section filed 5-23-94; operative 6-22-94 (Register 94, No. 21).

2. Amendment of section and Note filed 6-19-98; operative 7-19-98 (Register 98, No. 25).

3. Change without regulatory effect amending section filed 7-12-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 28). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

4. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§46. Method of Evaluation of Neuromusculoskeletal Disability.

(a) For all claims arising before January 1, 2005, not subject to section 46(b), the method of measuring the neuromusculoskeletal elements of disability shall be as set forth below in the "Guidelines for Evaluation of Neuromusculoskeletal Disability" as adopted by the Industrial Medical Council on October 20, 1994. The full text of this document is available on the web at no charge at www.dir.ca.gov/IMC/guidelines.html or by calling the Medical Unit at 1-800-794-6900.

(b) For all claims having dates of injury on or after January 1, 2005, and for those compensable claims arising before January 1, 2005, where there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the claims administrator, or if none the employer, is not required to provide the notice required by section 4061 to the injured worker, the method of measuring the neuromusculoskeletal elements of impairment shall be as described in the American Medical Association, Guides to the Evaluation of Permanent Impairment [Fifth Edition] (AMA Guides). Permanent disability shall be described by applying the provisions of the Permanent Disability Rating Schedule adopted by the Administrative Director pursuant to section 9805 of Title 8 of the California Code of Regulations.
Note: Authority cited: Section 133, 139.2(j)(2) and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4067, 4628 and 4660, Labor Code.

HISTORY

1. New section filed 4-18-96; operative 4-18-96 pursuant to Government Codesection 11343.4(d) (Register 96, No. 16).

2. Change without regulatory effect amending "Guidelines for Evaluation of Neuromusculoskeletal Disability, 2nd Ed." (incorporated by reference) filed 6-6-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 23).

3. Change without regulatory effect amending Note filed 8-1-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 31).

4. Amendment of section and Note filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

5. Change without regulatory effect amending section filed 7-12-2001 pursuant to section 100, title 1, California Code

of Regulations (Register 2001, No. 28). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

6. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§46.1. 1 Guidelines for the Evaluation of Foot and Ankle Disability.

(a) For all claims before January 1, 2005, not subject to section 46.1(b), the method of measuring the elements of foot and ankle shall be set forth below in the "Guidelines for Evaluation of Foot and Ankle Disability" as adopted by the Industrial Medical Council on October 28, 2000. The full text of this document is available on the web at no charge at www.dir.ca.gov/IMC/guidelines.html or by calling the Medical Unit at 1-800-794-6900.

(b) For all claims having dates of injury on or after January 1, 2005, and for those compensable claims arising before January 1, 2005, where there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the claims administrator, or if none the employer, is not required to provide the notice required by section 4061 to the injured worker, the method of measuring the elements of foot and ankle impairment shall be described in the American Medical Association, Guides to the Evaluation of Permanent Impairment [Fifth Edition] (AMA Guides). Permanent disability shall be described by applying the provisions of the Permanent Disability Rating Schedule adopted by the Administrative Director pursuant to section 9805 of Title 8 of the California Code of Regulations.

Note: Authority cited: Sections 139, 139.2, 4060, 4061 and 4062, Labor Code. Reference: Sections 139, 139.2, 4060, 4061, 4061.5 and 4062, Labor Code.

HISTORY

1. New section and appendices A-C filed 1-8-2003; operative 2-7-2003 (Register 2003, No. 2).

2. Repealer of section and Appendices A-C and new section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§46.1. 1 Guidelines for the Evaluation of Foot and Ankle Disability Appendix A

MUSCLE GRADING CHART

Results may be reported using a verbal scale or a percentage loss of muscle strength as follows. In either case, the evaluator must still describe how a given loss of muscle strength affects the injured worker's capacity to perform work.

MUSCLE GRADATION DESCRIPTION
5-Normal 5-complete range of motion against gravity withfull resistance
4-Good 4-complete range of motion against gravity withsome resistance
3-Fair 3-complete range of motion against gravity
2-Poor 2-complete range of motion with gravity eliminated
1-Trace 1-reads evidence of slight contractility, no joint motion
0 (Zero) 0-no evidence of contractility

EXAMPLES OF MUSCLE GRADING CHARTS

Results may be reported using a verbal scale or a percentage loss of muscle strength as follows. In either case, the evaluator must still describe how a given loss of muscle strength affects the injured worker's capacity to perform work.

MUSCLE GRADATION DESCRIPTION
5-Normal 5-complete range of motion against gravity withfull resistance
4-Good 4-complete range of motion against gravity withsome resistance
3-Fair 3-complete range of motion against gravity
2-Poor 2-complete range of motion with gravity eliminated
1-Trace 1-reads evidence of slight contractility, no joint motion
0 (Zero) 0-no evidence of contractility

KENDALL LOVETT DESCRIPTION
100 %95 % NormalNormal - The ability to hold the test position against gravity and maximum pressure, or the ability to move the part into test position and hold against gravity and maximum pressure
90 %80 %_ Good +Good Same as above except holding against moderate pressure.
70 %60 % Good -Fair + Same as above except holding against minimum pressure.
50 % Fair The ability to hold the test position against gravity, or the ability to move the part into test position and hold against gravity.
40 % Fair - The gradual release from test position against gravity; or the ability to move the part toward test position

against gravity almost to completion, or to completion with slight assistance or the ability to complete the arc of motion with gravity lessened.

KENDALL LOVETT DESCRIPTION
30 %20 % Poor +Poor The ability to move the part through partial arc of motion with gravity lessened; moderate arc, 30% or poor +; small arc, 20% or poor. To avoid moving a patient into gravity-lessened position, these grades may be estimated on the basis of the amount of assistance given during anti-gravity test movements: A 30% or poor + muscle requires moderate assistance, a 20% or poor muscle requires more assistance
10 %5 % Poor -Trace In muscles that can be seen or palpated, a feeble contraction may be felt in the muscle, or the tendon may become prominent during the muscle contraction, but there is no visible movement of the part.
0 % Gone No contraction felt in the muscle.

NOTE

Authority cited: Sections 139, 139.2, 4060, 4061 and 4062, Labor Code. Reference: Sections 139, 139.2, 4060, 4061, 4061.5 and 4062, Labor Code.

HISTORY

1. New section and appendices A-C filed 1-8-2003; operative 2-7-2003 (Register 2003, No. 2).

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§46.1. 1 Guidelines for the Evaluation of Foot and Ankle Disability Appendix B

Subjective disability should be described in terms of location, degree, frequency, and precipitating activity. Terms describing degree and frequency are taken to have the following meanings:

Degree:

Minimal or mild pain constitutes an annoyance, but causes no handicap in the performance of activity.

Slight pain can be tolerated but causes some handicap in the performance of precipitating activity.

Moderate pain can be tolerated but causes marked handicap in the performance of precipitating activity.

Severe pain precludes precipitating activity

Frequency:

Occasional -- approximately 25% of the time

Intermittent -- approximately 50% of the time

Frequent -- approximately 75% of the time

Constant -- approximately 100% of the time

NOTE

Authority cited: Sections 139, 139.2, 4060, 4061 and 4062, Labor Code. Reference: Sections 139, 139.2, 4060, 4061, 4061.5 and 4062, Labor Code.

HISTORY

1. New section and appendices A-C filed 1-8-2003; operative 2-7-2003 (Register 2003, No. 2).

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New query

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§46.1. 1 Guidelines for the Evaluation of Foot and Ankle Disability Appendix C

Appendix C

DESCRIPTION OF ACTIVITIES

BALANCING: Maintaining body equilibrium

BENDING: Angulation from neutral position about a joint (e.g. ankle) or spine (e. g. forward)

CARRYING: Transporting an object, usually holding it in the hands or arms or on the shoulder.

CLIMBING: Ascending or descending ladders, stairs, scaffolding, ramps, poles, etc. . . using feet and legs and/or hands and arms.

CRAWLING: Moving about on hands and knees and feet.

CROUCHING: Bending body downward and forward by bending lower limbs, pelvis and spine

JUMPING: Moving about suddenly by use of leg muscle, leaping from or onto the ground or from one object to another.

KNEELING: Bending legs at knees to come to rest on knee or knees.

LIFTING: Raising or lowering an object from one level to another (includes upward pulling)

PIVOTING: Planting your foot and turning about that point.

PUSHING: Exerting force upon an object so that the object moves away from the force (includes slapping, striking, kicking and treadle actions).

PULLING: Exerting force upon an object so that the object moves towards the force (includes jerking).

RUNNING: Moving in a fast pace, moving the legs rapidly so that for a moment both legs are off the ground.

SITTING: Remaining in the normal seated position.

SQUATTING: Crouching to sit on your heels, with knees bent and weight on the balls of your feet.

STANDING: Remaining on one's feet in an upright position at a work station without moving about.

STOOPING: Bending body downward and forward by bending spine at waist.

TURNING/ Moving about a central axis, revolve or rotate.
TWISTING:

USE FOOT Required to control a machine by use of controls.
CONTROLS:

WALKING: Moving about at a moderate pace over even or uneven ground.

NOTE

Authority cited: Sections 139, 139.2, 4060, 4061 and 4062, Labor Code. Reference: Sections 139, 139.2, 4060, 4061, 4061.5 and 4062, Labor Code.

HISTORY

1. New section and appendices A-C filed 1-8-2003; operative 2-7-2003 (Register 2003, No. 2).

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New query

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§47. Method of Evaluation of Immunologic Disability.

(a) For all claims before January 1, 2005, not subject to section 47(b), the method of measuring the immunologic elements of disability shall be set forth below in the "Guidelines for Immunologic Testing" as adopted by the Industrial Medical Council on March 17, 1994. The full text of this document id available on the web at no charge at www.dir.ca.gov/IMC/guidelines.html or by calling the Medical Unit at 1-800-794-6900.

(b) For all claims having dates of injury on or after January 1, 2005, and for those compensable claims arising before January 1, 2005, where there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notice required by section 4061 to the injured worker, the method of measuring the immunological elements of impairment shall be described in the American Medical Association, Guides to the Evaluation of Permanent Impairment [Fifth Edition] (AMA Guides). Permanent disability shall be described by applying the provisions of the Permanent Disability Rating Schedule adopted by the Administrative Director pursuant to section 9805 of Title 8 of the California Code of Regulations.

Note: Authority cited: Section 139.2(j)(2), Labor Code. Reference: Sections 139.2(j)(2), 4060, 4061 and 4062, Labor Code.

HISTORY

1. New section filed 5-23-94; operative 6-22-94 (Register 94, No. 21).

2. Amendment of Note filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Change without regulatory effect amending section filed 7-12-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 28). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

4. Amendment filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§48. QME Ethical Guidelines. [Repealed]

NOTE: Authority cited: Sections 139.2(j)(2) and (3) and 5307.3, Labor Code. Reference: Sections 139.2(j)(2) and (3), 4060, 4061 and 4062, Labor Code.

HISTORY

1. New section filed 5-23-94; operative 6-22-94 (Register 94, No. 21).

2. Repealer filed 4-11-95; operative 5-11-95 (Register 95, No. 15).

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New query

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§49. Definitions.

The following definitions apply to this Article:

(a) Cardiovascular evaluation. "Cardiovascular evaluation" means the determination of disability due to pathological changes of the heart and/or the central circulatory system.

(b) Face to Face time. "Face to face time" means only that time the evaluator is present with an injured worker. This includes the time in which the evaluator performs such tasks as taking a history, performing a physical examination or discussing the worker's medical condition with the worker. Face to face time excludes time spent on research, records review and report writing. Any time spent by the injured worker with clinical or clerical staff who perform diagnostic or laboratory tests (including blood tests or x-rays) or time spent by the injured worker in a waiting room or other area outside the evaluation room is not included in face to face time.

(c) Medical evaluation. "Medical evaluation" means a comprehensive medical-legal evaluation as defined under section 9793 of Article 5.6, Subchapter 1, Chapter 4.5 of Title 8 of the California Code of Regulations.

(d) Neuromusculoskeletal evaluation. "Neuromusculoskeletal evaluation" means the determination of disability due to injury to the central nervous systems, the spine and extremities, and the various muscle groups of the body.

(e) Psychiatric evaluation. "Psychiatric evaluation" means the determination of disability due to psychopathology, by either a psychiatrist or psychologist following the Method of Measurement of Psychiatric Disability set out in section 43 of Title 8 of the California Code of Regulations.

(f) Pulmonary evaluation. "Pulmonary evaluation" means the determination of disability due to pathological changes of the lungs and/or other components of the respiratory system.

(g) QME. "QME" means Qualified Medical Evaluator appointed by the Administrative Director pursuant to Labor Code section 139.2.

(h) Uncomplicated evaluation. "Uncomplicated evaluation" means a face to face evaluation in which all of the following are recorded in the medical report: Minimal or no review of records, minimal or no diagnostic studies or laboratory testing, minimal or no research, and minimal or no medical history taking.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062,

4062.1, 4062.2, 4067, 4628 and 4660, Labor Code.

HISTORY

1. Change without regulatory effect relocating article 4.5 heading and renumbering former section 149 to new section 49 filed 8-31-94 pursuant to section 100, title 1, California Code of Regulations (Register 94, No. 35).

2. Change without regulatory effect amending article heading filed 9-28-94 pursuant to section 100, title 1, California Code of Regulations (Register 94, No. 39).

3. Amendment of subsection (b) filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

4. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§49.2. Neuromusculoskeletal evaluation.

A medical evaluation concerning a claim for neuromusculoskeletal injury (whether specific or cumulative in nature) shall not be completed by a QME in fewer than 20 minutes of face to face time. Twenty minutes is the minimum allowable face to face time for an uncomplicated evaluation. The evaluator shall state in the evaluation report the amount of face to face time actually spent with the injured worker and explain in detail any variance below the minimum amount of face to face time stated in this regulation.

Note: Authority cited: Sections 133,139.2(j) and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4067, 4628 and 4660, Labor Code.

HISTORY

1. Change without regulatory effect renumbering former section 149.2 to new section 49.2 filed 8-31-94 pursuant to section 100, title 1, California Codeof Regulations (Register 94, No. 35).

2. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§49.4. Cardiovascular evaluation.

A medical evaluation concerning a claim for cardiovascular injury (whether specific or cumulative in nature) shall not be completed by a QME in fewer than 30 minutes of face to face time. Thirty minutes is the minimum allowable face to face time for an uncomplicated evaluation. The evaluator shall state in the evaluation report the amount of face to face time actually spent with the injured worker and explain in detail any variance below the minimum amount of face to face time stated in this regulation.

Note: Authority cited: Sections 133, 139.2(j) and 5307.3, Labor Code, Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4067, 4628 and 4660, Labor Code.

HISTORY

1. Change without regulatory effect renumbering former section 149.4 to new section 49.4 filed 8-31-94 pursuant to section 100, title 1, California Codeof Regulations (Register 94, No. 35).

2. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§49.6. Pulmonary evaluation.

A medical evaluation concerning a claim for pulmonary injury (whether specific or cumulative in nature) shall not be completed by a QME in fewer than 30 minutes of face to face time. Thirty minutes is the minimum allowable face to face time for an uncomplicated evaluation. The evaluator shall state in the evaluation report the amount of face to face time actually spent with the injured worker and explain in detail any variance below the minimum amount of face to face time stated in this regulation.

Note: Authority cited: Sections 133, 139.2(j) and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4067, 4628 and 4660, Labor Code.

HISTORY

1. Change without regulatory effect renumbering former section 149.6 to new section 49.6 filed 8-31-94 pursuant to section 100, title 1, California Codeof Regulations (Register 94, No. 35).

2. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§49.8. Psychiatric evaluation.

A medical evaluation concerning a claim for psychiatric injury (whether specific or cumulative in nature) shall not be completed by a QME in less than one hour of face to face time. One hour is considered the minimum allowable face to face time for an uncomplicated evaluation. The evaluator shall state in the evaluation report the amount of face to face time actually spent with the injured worker and explain in detail any variance below the minimum amount of face to face time stated in this regulation.

Note: Authority cited: Sections 133,139.2(j) and 5307.3, Labor Code. Reference: Sections 139, 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4067, 4628 and 4660, Labor Code.

HISTORY

1. Change without regulatory effect renumbering former section 149.8 to new section 49.8 filed 8-31-94 pursuant to section 100, title 1, California Codeof Regulations (Register 94, No. 35).

2. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§49.9. Other evaluation.

A medical evaluation concerning a claim for any injury (whether specific or cumulative in nature) not specifically included in this article shall not be completed by a QME in fewer than 30 minutes of face to face time. Thirty minutes is the minimum allowable face to face time for an uncomplicated evaluation. The evaluator shall state in the evaluation report the amount of face to face time actually spent with the injured worker and explain in detail any variance below the minimum amount of face to face time stated in this regulation.

Note: Authority cited: Sections 133,139.2(j) and 5307.3, Labor Code, Reference: Sections , 139.2 4060, 4061, 4062, 4062.1, 4062.2, 4067, 4628 and 4660, Labor Code.

HISTORY

1. Change without regulatory effect renumbering former section 149.9 to new section 49.9 filed 8-31-94 pursuant to section 100, title 1, California Codeof Regulations (Register 94, No. 35).

2. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 5. QME Reappointment

New query

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§50. Reappointment: Requirements and Application Form.

(a) In addition to the eligibility requirements set forth in section 11, a physician may seek reappointment on the basis that he or she was an active QME on June 30, 2000. For all physicians, applications for reappointment shall include a Reappointment Application Form in section 104, and the appropriate fee under section 17. The reappointment application and the appropriate fee shall be filed at the Administrative Director's headquarters office listed on the reappointment form.

(b) Any Reappointment Application Form may be rejected if it is incomplete or does not contain the required supporting documentation listed in section 11 and on the Reappointment Application Form. As part of the approval of the Reappointment Application Form, the Administrative Director shall verify that the QME has complied with all requirements under this Article.

(c) When a QME applies for reappointment, he or she shall submit a statement signed under penalty of perjury:

(1) attesting that he or she has completed the applicable QME continuing education requirement; and

(2) listing the dates, locations, and titles of the continuing education programs and the names of the providers of those programs which he or she has taken to meet the requirement of Labor Code section 139.2(d)(3), as well as the number of hours of attendance at each program. The Administrative Director may randomly audit QMEs for documentation of program attendance, which supports compliance with this requirement; and

(3) attesting that the physician has accurately reported on the QME SFI Form 124 to the best of the QME's knowledge the information required by section 29 regarding the QME's specified financial interests; and

(4) attesting that the physician's license to practice as a physician, as defined under Labor Code section 3209.3, is neither restricted nor encumbered by suspension or probation, nor has the physician been convicted of a misdemeanor or felony related to the physician's practice or a crime of moral turpitude, and that the physician will notify the Administrative Director if the physician's license to practice is subsequently suspended or placed on probation or if the physician is convicted of a misdemeanor or felony related to the physician's practice or of a crime of moral turpitude; and

(5) attesting that the physician shall abide by all regulations of the Administrative Director and shall refrain from making referrals in violation of those regulations; and

(6) attesting that the physician has not performed a QME evaluation during a time when the physician was not appointed as a QME.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, Labor Code.

HISTORY

1. New article 5 and repealer and new section filed 8-1-94; operative 8-31-94 (Register 94, No. 31). For prior history, see Register 91, No. 26.

2. Change without regulatory effect amending first paragraph and subsection (i) filed 4-19-95 pursuant to section 100, title 1, California Code ofRegulations (Register 95, No. 16).

3. Amendment of article 5 heading and renumbering of former section 50 to new section 53 and new section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

4. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

5. Amendment of section heading and section and new Note filed 9-6-2001; operative 10-6-2001 (Register 2001, No. 36).

6. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§50.1. Reappointment: Failure to Comply with Time Frames. (Renumbered)

Note: Authority cited: Section 139.2, Labor Code. Reference: Section 139.2(d)(1), Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Change without regulatory effect amending section filed 12-2-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No.49).

3. Renumbering of former section 50.1 to section 51 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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New query

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§50.2. Reappointment: Unavailability Notification. [Renumbered]

Note: Authority cited: Section 139.2, Labor Code. Reference: Sections 139.2(d) and 139.2(j)(6), Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).
2. Change without regulatory effect amending section filed 12-2-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 49).

3. Renumbering of former section 50.2 to section 52 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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New query

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§50.3. Reappointment: Evaluations Rejected by Appeals Board. [Renumbered]

Note: Authority cited: Section 139.2, Labor Code. Reference: Sections 139.2(d) and 139.2(j)(6), Labor Code.

HISTORY

1. New section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

2. Renumbering of former section 50.3 to new section 52 filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

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New query

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§51. Reappointment: Failure to Comply with Time Frames.

All QMEs shall comply with the time frames in sections 34 and 38 as a condition for reappointment. The Administrative Director may deny reappointment to any QME who has failed to comply with the evaluation time frames in sections 34 and 38 on at least three occasions during the calendar year.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Section 139.2(d)(1), Labor Code.

HISTORY

1. Repealer and new section filed 8-1-94; operative 8-31-94 (Register 94, No. 31). For prior history, see Register 91, No. 26.

2. Renumbering of former section 51 to new section 60 and new section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

3. Renumbering of former section 51 to section 53 and renumbering of former section 50.1 to section 51 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

4. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§52. Reappointment: Unavailability Notification.

All QMEs shall comply with the unavailability notification requirements in section 33 as a condition for reappointment. The Administrative Director may deny reappointment of any QME who has filed notification for unavailability under section 33 for more than 90 calendar days during the calendar year, or who has on any single occasion refused without good cause to perform a medical-legal evaluation.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2(d) and 139.2(j)(6), Labor Code.

HISTORY

1. Repealer and new section filed 8-1-94; operative 8-31-94 (Register 94, No. 31). For prior history, see Register 91, No. 26.

2. Renumbering of former section 52 to new section 61, renumbering of former section 50.3 to new section 52 and amendment of section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

3. Renumbering of former section 52 to section 54 and renumbering of former section 50.2 to section 52 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

4. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§53. Reappointment: Failure of Board Certification Examination [Reserved].

HISTORY

1. Repealer and new section filed 8-1-94; operative 8-31-94 (Register 94, No. 31). For prior history, see Register 91, No. 26.

2. Renumbering of former section 53 to new section 62, renumbering of former section 50 to new section 53 and amendment of section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

3. Amendment filed 3-15-99; operative 4-14-99 (Register 99, No. 12).

4. Renumbering of former section 53 to section 55 and renumbering of former section 51 to section 53 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

5. Repealer filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§53.1. QME Continuing Education Response Form. [Repealed]

Note: Authority cited: Section 139.2, Labor Code. Reference: Section 139.2, Labor Code.

HISTORY

1. New section filed 3-15-99; operative 4-14-99 (Register 99, No. 12).
2. Repealer filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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New query

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§54. Reappointment: Evaluations Rejected by Appeals Board.

The Administrative Director may deny reappointment to any QME who has had more than five evaluations rejected by a Workers' Compensation Judge or the Appeals Board originally submitted at a contested hearing. The rejection shall be based on the failure of the QME's evaluation to prove or disprove a contested issue or failure to comply with guidelines promulgated by the Administrative Director pursuant to Labor Code section 139.2(j)(2), (3), (4) or (5). A specific finding must become final and the time for appeal must have expired before any rejected evaluation shall be counted as one of the five rejections.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2(d) and 139.2(j)(6), Labor Code.

HISTORY

1. New section filed 5-9-91; operative 5-9-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section11351(a).

2. Repealer filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

3. Renumbering of former section 52 to section 54 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

4. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§55. Reappointment: Continuing Education Programs.v

A QME shall complete within the previous 24 months of his or her term of appointment 12 hours of continuing education in disability evaluation or workers' compensation related medical dispute evaluation given by a provider accredited by the Administrative Director.

(a) There are two types of continuing education programs:

(1) On-site programs, in which the instructor and QME are in the same location; and

(2) Distance learning programs.

(A) Providers of distance learning programs shall give either a pre- or post-course self-examination based on the program material. The provider shall grade the QME's test. Credit for the course can be given only for a passing rate of no lower than 70 percent correct responses. The Administrative Director may audit physicians' examinations and scores.

(B) Credit for distance learning courses shall be granted for the actual time spent viewing, listening to or participating in the program and for the reasonable and necessary time to take the examinations for up to six hours per program. Credit for the same distance learning program may be taken only once.

(C) All distance learning materials shall bear a date of release and shall be updated every three years. The provider shall notify the Administrative Director in writing of the revision.

(b) In addition to granting credit for attending a course or program which it gives, the Administrative Director may grant credit for:

(1) Participating in a panel on the development or review of the QME competency examination. A physician may receive one hour credit for each hour of participation on a panel. The QME shall obtain documentation of participation from the test administrator for submission to the Administrative Director.

(2) Instructing in a program given for QME credit by a provider accredited by the Administrative Director. The instructor may receive two hours of credit for each hour of instruction in an accredited provider's program or one hour of credit for each hour of participation on a panel. Credit for the same presentation may be taken only once during each calendar year. The QME shall submit documentation of participation from the program provider to the Administrative Director.

(3) Attending a program which is accepted by the QME's licensing board for renewal of his or her professional license, provided the subject matter is directly related to California impairment evaluation or workers' compensation medical dispute evaluation.

To request credit for this type of course, the QME must submit:

(A) proof of attendance;

(B) written material which describes the program content and program faculty; and

(C) documentation that the program is for continuing education credit by the physician's licensing board.

(4) Passing the QME competency examination. A QME may be granted six hours of continuing education credit for passing this examination for the purpose of receiving an initial appointment as a QME.

(c) To apply to the Administrative Director for accreditation, a provider shall submit to the Administrative Director, at least 60 calendar days before any public advertisement of the applicant's program or course is made:

(1) a completed form 118, in section 118 of these regulations.

(2) A curriculum vitae for each proposed instructor or author (for paper-based programs). A proposed instructor or author shall have education and/or training and recent work experience relevant to the subject of his/her presentation.

(3) The proposed promotional material for the program.

(4) An outline of course content, or actual course content, consistent with the topics in section 11.5(c) of Title 8 of the California Code of Regulations.

(d) The Administrative Director shall accredit an applicant who meets the definition of an education provider in Section 1(q); submits a completed, signed and dated application which demonstrates past experience in providing continuing education programs; and proposes a program which meets the requirements of section 55(c) or a course which meets the requirements of section 11.5(a) and (i). Proposed content for continuing education program credit must relate directly to disability evaluation or California workers' compensation-related medical dispute evaluation.

No credit shall be recognized by the Administrative Director for material solely discussing the business aspects of workers' compensation medical practice such as billing, coding and marketing.

(e) The Administrative Director shall notify the applicant within 30 calendar days after receipt of the application containing all the information listed in section 55(c) whether that provider has been accredited for a two year period. Incomplete applications will be returned to the applicant.

(f) A provider that has been accredited by the Administrative Director will be given a number which must be displayed on any public advertisements of QME continuing education programs for that provider with the statement "Accredited by the Administrative Director of the California Division of Workers' Compensation for Qualified Medical Evaluator continuing education. Physicians may report up to ____ hours of credit for QME reappointment."

(g) On or before the date the program is first presented or distributed, the provider shall submit the program syllabus (all program handouts) to the Administrative Director. Each distance learning program shall also submit one copy of the examinations and one copy of the audio/video tapes, computer program or each issue of the journal or newsletter for which credit is to be granted.

(h) A provider may offer different QME continuing education programs during the two-year accreditation period provided the subject matter is in disability evaluation or workers' compensation related medical dispute resolution. The provider shall send the Administrative Director the program outlined and faculty for each new program at least forty-five (45) days prior to the date of presentation of the new program. The Administrative Director may require submission of program syllabi. The Administrative Director may require changes in the program based on its review of the program outline, program syllabi, promotional material or faculty if the Administrative Director finds that any aspect of the program is not in compliance with these regulations.

(i) Promotional materials for a program must state the educational objectives; the professional qualifications of program faculty (at least all relevant professional degrees); the content of program activities; the maximum number of credit hours to be granted; and the intended audience.

(j) Joint sponsorship of education programs (as between an accredited and an unaccredited provider) must be approved by the Administrative Director prior to presentation of the program.

(k) Accredited providers that cease to offer education programs shall notify the Administrative Director in writing.

(l) Instructors shall not recruit members or promote commercial products or services immediately before, during or after a course. Providers or vendors may display/sell educational related to workers' compensation or applications for membership in an area adjoining a course. A course provider or faculty member shall disclose on QME Form 119 (Faculty Disclosure of Commercial Interest), located in section 119 of Title 8 of the California Code of Regulations, any significant financial interest in or affiliation with any commercial product or service held by faculty and discussed in a course and that interest or affiliation must be disclosed to all attendees. A provider shall file every Form 119 in its possession or in its control with the Administrative Director.

(m) The provider shall issue a certificate of completion to each QME who successfully completes a continuing education program. The certificate must list the provider; provider number; date(s); location and title of the

continuing education program; and the number of hours in attendance for which credit is to be granted. Credit shall be granted only for the actual time of attendance at or participation in a program. Each accredited provider may in its sole discretion limit the amount of credit hours that a course will be granted to less than the amount of time actually spent in attendance in the course.

(n) To apply for re-accreditation, a provider must submit a completed QME Form 118 (Application for Accreditation or Re-Accreditation as Education Provider) (See, 8 Cal. Code Regs. § 118). The provider may complete section 2 of the form using a new program or course or one which was given by the provider during the recent accreditation period. The Administrative Director shall give the provider ninety (90) days' notice of the need to seek re-accreditation.

(o) The provider shall maintain attendance records for each continuing education program for a period of no less than three (3) years after the program is given. A physician attending the program must be identified by signature. The provider must submit a copy of the signature list to the Administrative Director within sixty (60) days of completion of the program.

(p) The provider is required to give the QME's Evaluation Form 117 (Qualified Medical Evaluator Continuing Education Response Form) (See, 8 Cal. Code Regs. § 117) to program attendees and request they submit the form to the Administrative Director. This information shall not be used in lieu of a certification of completion given by the provider, as specified pursuant to section (m). Destruction by a provider or its employee of a QME's Evaluation Form or failure by such provider or its employee to distribute Form 117 as part of its program shall constitute grounds for revocation of a provider's accredited status. The Administrative Director shall tabulate the responses and return a summary to the provider within ninety (90) days of completion of the program.

(q) The Administrative Director may audit a provider's program(s) at the request of the medical director to determine if the provider meets the criteria for accreditation. The Administrative Director may audit programs randomly, when a complaint is received, or on the basis of responses on QME Form 117 (Qualified Medical Evaluator Continuing Education Response Form) (See, 8 Cal. Code Regs. § 117). An auditor shall not receive QME credit for an audited program. The Administrative Director shall make written results of the audit available to the provider no more than thirty (30) days after the audit is completed.

(r) The Administrative Director may withdraw accreditation of a provider or deny such a provider's application for accreditation on the following grounds (in addition to failure to meet the relevant requirements of subdivision 11.5(a) or 55(c) of Title 8 of the California Code of Regulations):

(1) Conviction of a felony or any offense substantially related to the activities of the provider.

(2) Any material misrepresentation of fact made by the provider.

(3) Failure to comply with Administrative Director regulations.

(4) False or misleading advertising.

(5) Failure to comply with Administrative Director recommendations following an audit.

(6) Failure to distribute QME Form 117 (Qualified Medical Evaluator Continuing Education Response Form) (See, 8 Cal. Code Regs. § 117) cards to program attendees.

Note: Forms referred to above are available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4062.3, 4067 and 4628, Labor Code.

HISTORY

1. New section filed 5-9-91; operative 5-9-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section11351(a).

2. Repealer filed 8-1-94; operative 8-31-94 (Register 94, No. 31).

3. Renumbering of former section 53 to section 55 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

4. Amendment of section heading and section filed 9-6-2001; operative 10-6-2001 (Register 2001, No. 36).

5. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 5. QME Reappointment
New query

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§56. Reappointment: Failure to Comply with WCAB Order or Ruling.

The Administrative Director may deny reappointment to any QME who has been found in violation of any order or ruling by a Workers' Compensation Judge or the Appeals Board.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2(d) and 139.2(j)(6), Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).
For prior history see Register 94, No. 31.

2. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 5. QME Reappointment

New query

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§57. Reappointment: Professional Standard -Violation of Business and Professions Code Section 730.

The Administrative Director may deny appointment or reappointment to any physician who has performed a QME evaluation or examination without valid QME certification at the time of examining the injured worker or the time of signing the initial or follow-up evaluation report.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code; and Section 730, Business and Professions Code. Reference: Sections 139.2(d) and 139.2(j)(6), Labor Code; and Section 730, Business and Professions Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

2. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 6. QME Discipline

New query

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§60. Discipline.

(a) The Administrative Director may, in his or her discretion, suspend or terminate any physician from the QME list without hearing:

(1) whose license has been revoked;

(2) whose license has been suspended or terminated by the relevant licensing board so as to preclude practice;

(3) who has been convicted of a misdemeanor or felony related to the conduct of his or her practice or who has been suspended or placed on probation by his or her licensing board;

(4) based on a stipulation or a decision by the physician's licensing board that the physician has been placed on probation;

(5) who has failed to pay timely the appropriate fee as required under section 17 of Title 8 of the California Code of Regulations.

(b) The Administrative Director may, based on a complaint by the Medical Director, and following a hearing pursuant to section 61 of Title 8 of the California Code of Regulations, suspend, terminate or place on probation a QME found in violation of a statutory or administrative duty as described in the Administrative Director Sanction Guidelines for QMEs under section 65 of Title 8 of the California Code of Regulations. Such violations include, but are not limited to:

(1) one violation of Labor Code section 139.3 or 4628;

(2) failure to follow the medical procedures established by the Administrative Director pursuant to Labor Code section 139.2(j)(1)(2)(3)(4)(5) or (6);

(3) failure to comply with the requirements of Labor Code section 139.2(b) or (c) and/or section 10, 10.5, 11 or 12 of Title 8 of the California Code of Regulations;

(4) failure to comply with the unavailability notification requirements pursuant to section 33 of Title 8 of the California Code of Regulations.

(5) failure to comply with the disclosure, ethical or conflict of interest requirements pursuant to sections 40, 41 or 41.5, respectively, of Title 8 of the California Code of Regulations;

(6) failure to complete accurate and complete reports pursuant to Labor Code section 139.2(i) or to comply with section 39.5 of Title 8 of the California Code of Regulations.

(7) one finding by the Appeals Board of ex parte contact by the QME prohibited by Labor Code section 4062.3.

(8) one finding by the Administrative Director that the QME solicited an injured worker to take over that worker's treatment for his or her workers compensation claim.

(9) failure to disclose a disqualifying conflict of interest as required by section 41.5 of Title 8 of the California Code of Regulations;

(10) failure to disclose a significant financial interest, as defined in sections 1(cc) and 29 of Title 8 of the California Code of Regulations.

(c) The Medical Director may file a complaint with the Administrative Director against a QME on any of the grounds listed in subsection (b) based on a complaint from a member of the public and/or the Medical Director's own initiative. The Medical Director may assign legal counsel and investigators to conduct all matters related to this Article.

(d) The powers and discretion of the Administrative Director are hereby delegated to the Medical Director of the Division, or his or her designee Associate Medical Director, with respect to:

(1) Conducting investigations and assigning investigators;

(2) Issuing subpoenas for testimony and/or production of documents;

(3) Propounding interrogatories;

(4) Receiving and filing requests for hearing and notices of defense;

(5) Setting and calendaring cases for hearing;

(6) Issuing notices of hearing;

(7) Assigning counsel; and

(8) Performing all other functions related to QME discipline under this Article, except for issuing statements of issues, issuing accusations and issuing disciplinary orders after hearing.

(e) A report prepared by a QME which has not been completed and served on one or more parties prior to the date of the final decision taken by the licensing board or the date of the conviction, whichever is earlier, shall be inadmissible before the Appeals Board and no party shall have liability for payment for the report.

Note: Authority cited: Sections 11180-11191, Government Code; Sections 111, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2 and 4062.3, Labor Code.

HISTORY

1. New article 6 (sections 60-62), renumbering of former section 51 to new section 60, repealer and new subsection (a), amendment of subsection (b), new subsection (b)(6) and subsection renumbering, and new subsections (b)(8) and (d) filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

2. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 6. QME Discipline

New query

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§61. Hearing Procedure.

(a) Where the Medical Director determines that there is prima facie evidence of any violation of section 60 of Title 8 of the California Code of Regulations, he or she shall make and submit a prima facie case of the violation to the Administrative Director.

(b) If the Administrative Director sustains the Medical Director's prima facie case, the QME shall be notified in writing of the determination and shall also be notified of his or her right to a hearing in accordance with Chapter 4 (commencing with Section 11370) and Chapter 5 (commencing with section 11500) and Part 1 of Division 3 of the Government Code.

(1) The Administrative Director may, notwithstanding Government Code section 11502, assign the hearing to a hearing officer designated by the Medical Director who shall act as an Administrative Law Judge for the purposes of Government Code sections 11370 et. seq. and 11500 et. seq., or may delegate in whole or in part to an Administrative Law Judge the authority to conduct the hearing and decide the case. In the event of a hearing, the hearing officer or Administrative Law Judge shall fix the time and place of the hearing and notify interested parties in writing no fewer than 10 days in advance of the hearing and in accordance with Code of Civil Procedure sections 1013(a) and 2015.5 specifying the time and place of the hearing.

(2) If an Administrative Law Judge conducts a hearing, the Administrative Law Judge selected to preside over the hearing shall hear the case alone, and exercise all powers related to the conduct of the hearing.

(3) At the conclusion of the hearing, the Administrative Law Judge or hearing officer shall file a written statement of findings and proposed decision with the Administrative Director. The decision made pursuant to this action shall include specific findings in accordance with section 60(b) of Title 8 of the California Code of Regulations, and under section 65 of Title 8 of the California Code of Regulations shall recommend, but defer to the Administrative Director the final decision with respect to sanctions.

(4) The Administrative Director's decision on which sanction(s) to impose on a QME, pursuant to Labor Code section 139.2(k) or any other statute giving the Administrative Director disciplinary authority, shall be in accordance with the Sanction Guidelines for Qualified Medical Evaluators under section 65 of Title 8 of the California Code of Regulations.

(5) In accordance with Government Code section 11517(c), if the proposed decision is not adopted by the Administrative Director, the Administrative Director shall determine whether or not to decide the case, based on the record and transcript, and/or whether or not to take additional evidence or to refer the case back to the Administrative Law Judge to take additional evidence on any issue or issues requested by the Administrative Director.

(6) Within thirty (30) days of the date the written decision is served upon the QME, the QME may file a petition for reconsideration with the Administrative Director. The petition shall be governed by Government Code section 11521 and shall set forth any legal or factual basis as to why the decision should not be confirmed.

(c) Judicial Review of the Administrative Director's decision may be had by the filing of a petition for writ of mandate pursuant to Government Code Section 11523 no later than thirty (30) days after the last day on which the Administrative Director can order reconsideration in accordance with (b)(6) of this section.

Note: Authority cited: Sections 133, 139.2, 5307.3 and 5307.4, Labor Code; and Sections 11370 et seq. and 11500 et seq., Government Code. Reference: Section 139.2, Labor Code; and Sections 11502 et seq., Government Code.

HISTORY

1. Renumbering of former section 52 to new section 61, and amendment of subsections (c) and (d) filed 8-23-96; operative 9-22-96 (Register 96, No.34).

2. Repealer and new section and amendment of Note filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 6. QME Discipline

New query

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§62. Probation.

(a) A physician on probationary status from his or her licensing authority may be placed on probationary status by the Council in its discretion in accordance with IMC Sanction Guidelines under Section 65 of this Title.

(b) A QME on probationary status from the Council may be required to report periodically to the Medical Director to ensure compliance with any conditions of probation that have been imposed by the Council. These conditions may include the completion of specific courses and training.

(c) A QME shall be deemed to have passed probation and be eligible for reappointment if he or she has complied with the conditions imposed by the Council during the probation period, and meets the requirements for reappointment in accordance with Article 5.

(d) A QME shall be deemed to have failed probation if upon completion of the probation period it is determined that he or she has not complied with the conditions imposed by the Council during the probation period, and/or has failed to meet the requirements for reappointment in accordance with Article 5.

(e) The Council shall terminate probation, which shall be equivalent to a failure to pass probation, before completion of the probation period if during the probation period it is determined that a QME has not complied with the conditions of probation.

NOTE: Authority cited: Sections 139 and 139.2, Labor Code. Reference: Sections 139.2, 4060, 4061 and 4062, Labor Code.

HISTORY

1. Renumbering of former section 53 to new section 62, new subsection (a) and subsection relettering, and amendment of subsections (c) and (d) filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

2. Amendment of subsections (a), (c) and (d) filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

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Article 6. QME Discipline

New query

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§63. Denial of Appointment or Reappointment.

(a) Whenever the Administrative Director determines that an application for appointment or reappointment as a Qualified Medical Evaluator will be denied, the Administrative Director shall:

(1) Notify the applicant in writing of the decision to deny the application and the reasons for the denial; and

(2) Provide notice that if the applicant submits a specific, written response to the notice of denial within thirty (30) days, the Administrative Director will review the decision to deny the application, and within sixty (60) days of receipt of the response notify the applicant of the Administrative Director's final decision.

(b) If the applicant fails to submit a specific, written response to the notice of denial within thirty (30) days, the decision to deny shall become final without any further notice.

(c) If the applicant submits a specific, written response, and the Administrative Director's final decision is that the application should be denied, notice of the final decision shall be provided to the applicant by means of a statement of issues and notice of right to hearing under Chapter 5 (commencing with section 11500) of Title 2 of the Government Code.

(d) All notices and response under this section shall be made by certified mail.

Note: Authority cited: Sections 133, 139.2(f) and 5307.3, Labor Code; Section 11500 et seq., Government Code. Reference: Section 139.2, Labor Code.

HISTORY

1. New section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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New query

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§65. Sanction Guidelines for Qualified Medical Evaluators.

The guidelines for determining appropriate sanctions for physicians licensed as Qualified Medical Evaluators shall be set forth in the Sanction Guidelines for Qualified Medical Evaluators as adopted by the Industrial Medical Council on October 21, 1999, and re-adopted and enforced by the Administrative Director.

Sanction Guidelines for Qualified Medical Evaluators

I. PART ONE-OVERVIEW

The purpose of these guidelines is to provide the framework of the Administrative Director's (AD) disciplinary process for those affected by it - Qualified Medical Evaluators, the Administrative Director, administrative law judges with the Office of Administrative Hearings, licensing boards and other interested parties. These guidelines are not intended to be an exhaustive list of violations or disciplinary actions that the Administrative Director may consider against any QME. Any violation of statutory or administrative duties may constitute grounds for discipline under these guidelines.

The Administrative Director believes that education is the most effective course of action in resolving less serious regulatory violations. These guidelines also set out the parameters for discipline for misconduct considered serious.

The Administrative Director recognizes the need to promulgate uniform guidelines for particular violations in order to establish consistency in imposing disciplinary sanctions for similar offenses. The Administrative Director also recognizes that mitigating or aggravating circumstances in a specific case may necessitate variance from these guidelines.

In the event of a hearing, if an administrative law judge finds that the circumstances of a particular case are not adequately addressed in these guidelines, the Administrative Director may request that the administrative law judge include in the proposed decision an explanation of the recommended sanction and/or terms of probation, so those circumstances are better understood by the Administrative Director during its review of the case for ultimate action.

. Factors to be Considered in Determining Disciplinary Penalties

In cases of violations of Labor Code sections 139.2(k) and 139.2(m) and/or section 60 of Title 8 of the California Code of Regulations, the Administrative Director may impose discipline, up to and including suspension or termination, upon any physician certified by the Administrative Director as a Qualified Medical Evaluator.

In determining the level of the penalty to be imposed in a given case pursuant to section 61 of Title 8 of the California Code of Regulations, the following factors shall be considered:

(1) the seriousness of the violation including actual or potential harm to the public and any mitigating or rehabilitation evidence;

(2) whether or not a violation is an isolated incident or part of a pattern of behavior indicative of a disregard for the QME rules; e.g. (prior warnings of record; number and/or variety of current violations, time passed since the act(s) or offense(s));

(3) whether or not a violation is intentional as opposed to negligent;

(4) whether or not there is a history of previous violations cited under this section or by another court or tribunal (e.g.: prior disciplinary record, including level of compliance with disciplinary orders, compliance with terms of any criminal sentence, overall criminal record); and

(5) whether or not further education or training would be beneficial.

B. Mitigating Evidence

A respondent may present evidence at a hearing or in the settlement process and shall have the burden of demonstrating mitigating circumstances and/or any rehabilitative or corrective measures he or she has taken. The Administrative Director does not intend, by the following references to written statements, letters, and reports, to waive any evidentiary objections to the form of such evidence. The following are examples of appropriate evidence a respondent may submit to demonstrate his/her rehabilitative efforts and competency:

(1) Recent, dated written statements from persons in positions of authority who have on-the-job knowledge of the respondent's current competence in the practice of his or her specialty. Each statement should include the period of time and capacity in which the person worked with the respondent and should be signed under penalty of perjury. All letters will be subject to verification by the Administrative Director's staff.

(2) Recent, dated letters from counselors regarding the respondent's participation in a rehabilitation or recovery program, where appropriate. These should include at least a description and requirements of the program, a psychiatric diagnosis and current state of recovery and the psychiatrist's/psychologist's basis for determining need for rehabilitation.

(3) Recent, dated letters describing respondent's participation in support groups, (e. g. Alcoholics Anonymous, Narcotics Anonymous, Professional Support Groups, etc.), where appropriate.

(4) Recent, dated laboratory analyses or drug screen reports, where appropriate.

(5) Recent, dated performance evaluation(s) from the respondent's employer(s).

(6) Recent, dated physical examination or assessment report by a licensed physician, if appropriate.

In the above examples, the mitigating circumstances and/or rehabilitative efforts shall be detailed in any proposed decision or any transmittal memorandum accompanying a proposed stipulation.

C. Terms of Probation-Standard Conditions

If probation is imposed as part of a disciplinary action, the probation shall include: (1) Standard conditions, which will apply in all cases; and may include (2) Optional conditions, which will vary according to the nature of the offense(s) in the particular case.

The number in parenthesis refers to the paragraph number found in the sample Model Disciplinary Order, found in Part Two of these guidelines.

1. Obey all laws (#7);

2. File quarterly reports (#8);

3. Probation surveillance program compliance (#9);

4. Interviews with the Administrative Director's designee (#10);

5. Notation of probationary QME status (#33);

6. Tolling of probation, if out of state or while QME status inactive (#11);

7. Violation of probation extends Administrative Director jurisdiction (#13);

8. Reporting probationary status to Licensing Board (#6);

9. Reporting probationary status to parties since date of prior licensing board action or prior conviction (#6);

10. QME certificate surrender (if suspended or terminated) (#14).

D. Terms of Probation-Optional Sanctions and Conditions of Probation: The following optional sanctions and

conditions of probation may be imposed by the Administrative Director for proven or stipulated violations of the statutes or regulations cited.

Range of Optional Conditions:

1. Completion of a continuing education and/or ethics course related to the misconduct resulting in discipline (#17);

2. Completion of a QME ethics course (#17);

3. Monitoring of practice by another physician in the same area of practice, with periodic reports to the Administrative Director (#23);

4. Pass a written exam administered by the Administrative Director (#19);

5. Pass an oral exam administered by the Administrative Director (#19);

6. (For sexual transgressions) Requiring the presence of a designated third person during all medical/legal exams (#21);

7. Undergo psychiatric evaluation and/or psychiatric treatment (#24, #25);

8. Structured supervised practice (#22);

9. Undergo medical evaluation or treatment (#26, #27);

10. Abstain from drugs (#30);

11. Abstain from alcohol (#32);

12. Biological fluid testing (#28);

13. Maintain Controlled Substances Log (#31);

14. Diversion program (#29);

15. Restitution of monies received (#20);

16. Actual suspension during probation (#16);

17. Require QME to submit up to the next 5 med/legal reports to the Administrative Director (#34);

18. Print and distribute corrected information after advertising violation (#35).

The Administrative Director may also impose other conditions appropriate to the case which are not contrary to public policy or existing law.

II. Part Two-Violations and Sanctions

The Administrative Director may impose disciplinary sanctions for violations by a Qualified Medical Evaluator of any material statutory or administrative duty (Labor Code § 139.2(k)(1)).

Actions by a Qualified Medical Evaluator for which disciplinary action is appropriate are specified in the California Labor Code, the California Business and Professions Code, the California Penal Code, and Titles 8 and 16 of the California Code of Regulations.

Accordingly, the following, disciplinary sanctions shall be applied by the Administrative Director when a QME is found to be in violation of a material statutory and/or administrative duty.

A. Maximum Sanctions

1. Maximum sanction: Revocation of QME status.

2. Violations of material statutory administrative duties which shall result in the maximum sanctions are:

a. Professional licensure has been terminated (Labor Code § 139.2(m));

b. Conviction of a felony or misdemeanor (including billing/insurance fraud) related to the conduct of the physician's practice (Labor Code § 139.2(m));

c. Conviction of a felony or misdemeanor for a crime of moral turpitude (Labor Code § 139.2(m));

d. Arranging for the impersonation of a QME or impersonating a physician in the QME competency exam;

e. Arranging for the impersonation of a QME or impersonating another physician during QME evaluation;

f. Performing QME evaluations without QME certificate or while knowing that their QME status is suspended;

g. Failure to file a notice of defense to an accusation filed by the Administrative Director or failure to appear at disciplinary hearing initiated by the Administrative Director;

h. Failure to pay the required QME fee (Labor Code § 139.2(n));

i. False statements made under penalty of perjury relating to medical/QME licensing and/or specialty credentials.

3. If warranted, the maximum penalty can be imposed in any case.

B. Violations of Material Statutory/Administrative Duties Which May Result in Alternative Sanctions

1. Sexual Misconduct (Labor Code § 139.2(k); Bus. & Prof. Code § 726)

Minimum sanction: Stayed revocation, 7 years probation and:

a. Approved education course on sexual harassment, to be completed within 90 days (#17); and

b. Require third party present during all workers' compensation related evaluations and treatment (# 21); and

If warranted, any or all of the following:

c. Psychiatric evaluation and/or psychotherapy (#24, #25);

d. Required supervised workers' compensation related practice environment (#22 or #23);

e. Actual suspension at least one (1) year, under the criteria of PART ONE A.

2. Abuse of Drugs or Alcohol and/or Intoxication While Evaluating or Treating Patients (Labor Code § 139.2(k); Bus. & Prof. Code § 2239)

Minimum sanction: Stayed revocation, five (5) years probation and:

a. Evaluation by Diversion Program of appropriate licensing board and follow its recommendations;

b. If a Diversion Program is not available through the licensing board, then will be evaluated by an alcohol/drug rehabilitation program acceptable to the Administrative Director and will follow its

recommendations;

c. Allow the pertinent program to report on status to the Administrative Director;

d. Abstain from use (#30, #32); and

If warranted:

e. Cease performing QME evaluation while being evaluated by the Diversion Program;

f. Biological fluid testing (#28);

g. Maintain controlled substances log (#31);

h. Structured supervised practice (#22);

i. Monitored practice (#23);

j. Oral or written exam (#19);

k. Actual suspension.

3. Billing/Insurance Fraud or Submitting False Documents (Labor Code § 139.2(k); Bus. & Prof. Code § 2234(e); Bus. & Prof. Code § 2261; Bus. & Prof. Code § 810)

Minimum sanction: Stayed revocation and 5 years probation, and:

If warranted, any or all of the following:

a. Approved ethics course within 90 days (#17);

b. Restitution of amounts received (#20);

c. Pass oral or written exam (#19);

d. Actual suspension at least 6 months, under the factors of PART ONE A.;

e. Maximum sanctions.

4. False Statements Made Under Penalty of Perjury on QME Application Forms or Other QME or DWC Documents (Labor Code § 139.2(k); 8 Cal. Code. Regs § 11; Labor Code § 139.2(b); Labor Code § 139.2(c); Labor Code § 139.2(d); Bus. & Prof. Code § 2234(e); Bus. & Prof. Code § 2261)

(Ex.: False statement on QME exam application, appointment application or reappointment application regarding:

- probationary professional license status;

- past criminal conviction related to professional practice;

- completion of minimum continuing education, teaching or practice criteria for appointment or reappointment;

- time spent in direct patient treatment;

- number of QME or AME evaluations done in prior year(s) for purpose of annual fee or for reappointment;

- extent of AME work in lieu of direct patient treatment;

(Representing self as QME with active status when status lapsed).

Minimum sanction: Stayed revocation and 5 years probation, and:

If warranted, any or all of the following:

a. Actual suspension at least 90 days (#16) under the factors of PART ONE A.;

b. Approved ethics course within 90 days (#17).

5. Advertising Violations (Labor Code § 139.2(k); Labor Code § 139.4; Labor Code §§ 5430-5434; 8 Cal. Code Regs. § 153; 8 Cal. Code Regs. §§ 9820-9837) and conduct including:

- misleading or deceptive advertising - Bus. & Prof. Code § 2271, 651

- failure to include required fraud warning - Labor Code §§ 5432, 5433

- anonymous advertising - Bus. & Prof. Code § 2272

- misuse of title 'M.D.', 'D.O.', 'doctor', etc. Bus. & Prof. Code §§ 2275, 2276

- use of fictitious name without permit (Bus. & Prof. Code § 2285)

Minimum sanction: Educational material to be provided by the Administrative Director, and:

If warranted, any or all of the following:

a. Stayed revocation 3 years probation;

b. Approved ethics course within 90 days (#17);

c. Oral or written exam by Administrative Director (#19);

d. Print and distribute correct information (#35);

e. Pay for ad(s) in WC publications advising readers of statutes and regulations on permissible advertising;

f. Actual suspension at least 90 days (#16) under the factors of PART ONE A.;

g. Maximum sanctions.

6. Soliciting or Providing Treatment in Course of QME Evaluation (Labor Code 139.2(k); 8 Cal. Code Regs. §§ 11(d) and 41(a)(4))

Minimum sanctions: Educational material to be provided by the Administrative Director, and:

If warranted, any or all of the following:

a. Stayed revocation, one (1) year probation;

b. Approved ethics course (#17) within 90 days;

c. Restitution of amounts received for report to payor (#20);

d. Actual suspension at least 30 days (#16) under the factors of PART ONE A.

7. Self Interested Referral (Labor Code §§ 139.2(k) or 139.2(o); Labor Code § 3215; 8 Cal. Code Regs. §§ 41 or 41.5; Labor Code § 139.3)

Minimum sanction: Educational materials to be provided by Administrative Director, and:

If warranted, any or all of the following:

a. Stayed revocation and five (5) years probation;

b. Restitution of amounts received from unlawful referrals (#20);

c. Approved ethics course within 90 days (#17);

d. Actual suspension one (1) year (#16), under the factors of PART ONE A;

e. Maximum sanctions.

8. Ex Parte Communication (Labor Code § 139.2(k), Labor Code § 4062.3, 8 Cal. Code Regs. § 41(b))

Minimum sanction: Educational material to be provided by the Administrative Director, and:

If warranted, any or all of the following:

a. Stayed revocation, one (1) year probation;

b. Approved ethics course within 90 days (#17);

c. Restitution of amounts received for report to payor (#20);

d. Actual suspension at least 30 days, under the factors of PART ONE A;

e. Maximum sanctions.

9. Violations of QME Ethical and/or other Regulations

Conduct including but not limited to:

- refusing to schedule unrepresented cases (8 Cal. Code Regs. § 41(a)(2))

- routinely requiring IWs to wait over one hour (8 Cal. Code Regs. § 41(f))

- rescheduling panel QME exam 3 or more times per case (8 Cal. Code Regs. § 41(a)(7))

- switching location of QME exam to address not on QME panel letter (8 Cal. Code Regs. § 34(b))

- failing to serve QME appointment notification form/3 or more instances (8 Cal. Code Regs. § 34(a))

- failure to submit evaluations upon request by the Medical Director

- failure to timely notify the parties of a disqualifying conflict of interest (8 Cal. Code Regs. § 41.5)

- failure to report specified financial interests (8 Cal. Code Regs. §§ 1(ee) and 29)

Minimum sanction: Educational material to be provided by the Administrative Director, and

If warranted, any or all of the following:

a. Stayed revocation six (6) months probation under the factors of PART ONE A;

b. Approved ethics course within 90 days (#17);

c. Oral or written exam by Administrative Director (#19);

d. Actual suspension up to 180 days (#16) under the criteria of PART ONE A.

e. Maximum sanction.

10. False Statements in Medical/Legal Report (Labor Code § 139.2(k); 8 Cal. Code Regs. § 41(c)(4); Cal. Code Regs. § 4628, Including Ghostwriting)

- Involving a reckless disregard for available information or facts known to the physician.

Minimum sanction: Stayed revocation and five (5) years probation, with:

a. Approved ethics course within 90 days (#17); and

If warranted, any or all of the following:

b. Actual suspension, up to one year under the factors of PART ONE A.

c. Maximum sanctions.

11. Failure to Spend Requisite Face-to-Face Time

- minimum face-to-face time in evaluation (Labor Code § 139.2(k); Labor Code § 4628; 8 Cal. Code Regs. § 49 et seq.)

- in billing for medical/legal report (Labor Code § 139.2(k); Labor Code § 4628; 8 Cal. Code Regs. § 9795).

Minimum sanction: Educational materials to be provided by the Administrative Director.

If warranted, any or all of the following:

a. Stayed revocation, up to one (1) year probation and

b. Approved education course on related workers' compensation billing regulations (#17);

c. Restitution to payor (#20);

d. Approved ethics course, to be completed within 90 days (#17);

e. Actual suspension of at least 90 days, under the factors of PART ONE A;

f. Maximum sanctions.

12. Knowing Misrepresentation or Intentional Failure to Disclose Roles of Others Assisting with Medical/Legal Evaluation or Report, (Labor Code § 139.2(k); Labor Code § 4628) or Interference with or Obstruction of an

Investigation by the Medical Director into a Complaint Against a QME (Labor Code 139.2(J)(6).)

Minimum sanction: Stayed revocation, one (1) year probation, and:

If warranted, any or all of the following:

a. Educational material to be provided by the Administrative Director;

b. Approved ethics course within 90 days (#17);

c. Restitution of amounts received for report to payor (#20);

d. Actual suspension at least 90 days, under the criteria of PART ONE A (#16);

e. Maximum sanctions.

13. Performing Unnecessary Medical Tests in Capacity as QME or AME (Labor Code § 139.2(k); 8 Cal. Code Regs. § 41(a)(3); Bus. & Prof. Code § 725; Bus. & Prof. Code § 2234(e))

Minimum sanction: Educational material to be provided by the Administrative Director, and:

If warranted, any or all of the following:

a. Stayed revocation and up to five (5) years probation, and;

b. Restitution of amounts received for unnecessary tests (#20);

c. Pass oral or written exam (#19);

d. Completion of an approved clinical course (#18);

e. Approved ethics course within 90 days (#17);

f. Actual suspension, at least 90 days under the factors of PART ONE A;

g. Maximum sanctions.

14. Late Reports (Labor Code § 139.2(k); Labor Code § 139.2(j)(1); 8 Cal. Code Regs. § 38; 8 Cal. Code Regs. § 60(b)(4) (3 or more instances))

Minimum sanction: Educational material to be provided by the Administrative Director, and:

If warranted, any or all of the following:

a. Stayed of revocation, six (6) months probation;

b. Approved ethics and/or office management course within 90 days (#17);

c. Suspension of 30 days (#16) under the factors of PART ONE A.

15. Failure to Follow AD Evaluation Guidelines (Labor Code § 139.2(h); Labor Code § 139.2(k); Labor Code § 4628; 8 Cal. Code Regs. § 41(c)(5))

- Involving 3 or more instances

Minimum sanction: Educational material to be provided by the Administrative Director, and:

If warranted, any or all of the following:

a. Approved course in medical/legal report writing within 90 days (#17);

b. Stayed revocation, one (1) year probation;

c. Actual suspension 30 days (#16), under the factors of PART ONE A.

16. Report Deficiencies (Labor Code § 139.2(k))

- Defective declaration(s) required by Labor Code § 4628;

- Serving an unsigned report;

- Omitting discussion in a report of relevant information provided to QME;

- Inadequate or incorrect discussion of factors of disability;

- Other report deficiencies identified by Administrative Director quality review panel;

- Other report deficiencies that affect the substantial rights of a party and are in violation of the regulations governing QMEs;

- Determinations by DEU that a report is not ratable;

- Decisions of Administrative Director granting rating reconsideration;

- Omitting declaration(s) required by Labor Code § 4628.

Minimum sanction: Educational material to be provided by the Administrative Director, and:

If warranted, any or all of the following:

a. Require QME to submit up to five medical/legal reports to the Administrative Director medical/legal quality review staff (#34);

b. Approved course(s) in medical/legal report writing within 90 days (#17);

c. Oral or written exam by Administrative Director (#19);

d. Probation (six (6) months).

17. Report Deficiencies Affecting Admissibility (Labor Code § 139.2(k))

- Three Finding(s) by WCJ under Labor Code § 4628(e) or Labor Code § 139.2(d)(2)

Minimum sanction: Stayed revocation, one (1) year probation, and:

If warranted, any or all of the following:

a. Approved course(s) in medical/legal report writing within 90 days (#17);

b. Require QME to submit next five medical/legal reports to the Administrative Director medical/legal quality review staff (#34);

c. Oral or written exam by Administrative Director (#19).

18. Violation of Probation

Minimum sanction:Impose an actual period of suspension (Refer to #3, #4, or #5)

III. PART THREE-SAMPLE MODEL DISCIPLINARY ORDERS

A. The Administrative Director's disciplinary order may include, but are not limited to:

1. Revocation-Single Cause

QME certificate number(s) _____ issued to Respondent _____ is/are revoked.

2. Revocation-Multiple Causes

QME certificate number(s) _____ issued to Respondent _____ is/are revoked, pursuant to the Determination of Issues (Ex. I, II, and III separately and for all of them.)

3. Actual Suspension-Single Cause

QME certificate number(s) _____issued to Respondent _____ is/are suspended for (state time period). Actual suspension starts on the 16th day after the effective date of this decision.

4. Actual Suspension-Multiple Causes (To Run Concurrently)

QME certificate number(s) _____ issued to Respondent _____ is/are suspended for (state time period), pursuant to Determination of Issues (enter ¶ numbers), separately and for all of them. All suspensions shall run concurrently. Actual suspension starts on the 16th day after the effective date of this decision.

5. Actual Suspension-Multiple Causes (To Run Consecutively)

QME certificate number(s) _____ issued to Respondent _____ is/are suspended for (state time period), pursuant to Determination of Issues (enter ¶ number(s)); and (state time period), pursuant to Determination of Issues (enter ¶ number(s)). These suspension shall run consecutively, for a total period of (enter total time period). Actual suspension starts on the 16th day after the effective date of this decision.

6. Standard Stay Order

However, (revocation/suspension) is stayed and Respondent _____ is placed on probation for (enter time period) upon the following terms and conditions. Within 15 days after the effective date of this decision, the Respondent shall provide the Administrative Director (AD), or his/her designee, proof that Respondent has served a true copy of this decision on:

(a) Respondent's professional licensing board in California;

(b) Every party for whom Respondent has a pending QME or AME evaluation exam or medical/legal report due;

(c) The Court Administrator of the Division of Workers' Compensation, for distribution to Workers' Compensation Administrative Law Judges;

(d) The President of the California Applicants' Attorneys Association;

(e) The President of the California Defense Attorneys Association.

In the event Respondent's probation was imposed by the Administrative Director pursuant to Labor Code § 139.2(m), due to an order by Respondent's professional licensing board which suspended or imposed probationary status on Respondent's professional license, or due to a misdemeanor or felony conviction related to Respondent's practice or for a crime of moral turpitude, Respondent shall also provide the Administrative Director proof that a true copy of this decision was served on every party for whom Respondent wrote a medical/legal report from the date of the licensing board action or the date of the criminal conviction until the effective date of this decision.

7. Obey All Laws

Respondent shall obey all federal, state and local laws and regulations, all rules governing practice as a Qualified Medical Evaluator, all rules in California governing Respondent's professional area of practice, and remain in full compliance with any court ordered criminal probation, payments and other orders.

8. Quarterly Reports

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Administrative Director, stating whether there has been compliance with all the conditions of probation.

9. Probation Surveillance Program Compliance

Respondent shall comply with the Administrative Director's probation surveillance program. Respondent shall, at all times, keep the Administrative Director informed of his or her addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the assigned Administrative Director probation monitor. Under no circumstances shall a post office

box serve as an address of record.

Respondent shall also immediately inform the Administrative Director, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

10. Interview with the Administrative Director or Designee or Designated Physicians

Respondent shall appear in person for interviews with the Administrative Director, his/her designee or his/her designated physician(s) or medical consultant(s), upon request at various intervals and with reasonable notice.

11. Tolling for Out-of-State Practice or Residence, for Periods of Inactive QME Status, or for In-State Non-Practice

In the event Respondent should leave California to reside or to practice outside the State, or for any reason should Respondent's QME status become inactive in California, Respondent shall notify the Administrative Director probation monitor in writing within ten (10) days of the dates of departure and return, or the dates of inactive QME status in California. Non practice is defined as any period of time exceeding thirty (30) days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Administrative Director or its designee shall be considered as time spent in practice.

Periods of temporary permanent residence or practice outside California or periods of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

12. Completion of Probation

Upon successful completion of probation, Respondent's QME certificate(s) shall be fully restored.

13. Violation of Probation

If Respondent violates probation in any respect, the Administrative Director, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against Respondent during probation, the Administrative Director shall have continuing jurisdiction until the matter is final and the period of probation shall be extended until the matter of the new accusation or petition to revoke is final.

14. QME Certificate Surrender

Following the effective date of this decision, if Respondent ceases practicing as a Qualified Medical Evaluator, due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may voluntarily tender his/her QME certificate(s) to the Administrative Director. The Administrative Director reserves the right to evaluate Respondent's request and to exercise its discretion whether to grant the

request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered QME certificate(s), Respondent will no longer be subject to the terms and conditions of probation.

15. Notation of Probationary QME Status

Upon the effective date of this decision, the Administrative Director shall make a notation on each letter sent to an unrepresented injured worker, which lists Respondent's name on a panel of QMEs, indicating that Respondent is currently on probation as a QME. Administrative Director also shall make a notation next to Respondent's name wherever it appears in each QME roster issued during the period in which Respondent is on probation on the date the roster is issued. Respondent shall answer truthfully any questions from injured workers or other parties about Respondent's probationary QME status.

B. Optional Conditions of Probation

16. Actual Suspension as Part of Probation

As part of probation, Respondent is suspended from performing any function as a Qualified Medical Evaluator or an Agreed Medical Evaluator for (enter total time period for suspension), beginning on the sixteenth (16th) day after the effective date of this decision.

17. Approved Ethics or other Educational Course

Within thirty (30) days of the effective date of this decision, Respondent shall submit to the Administrative Director or his/her designee for his/her prior approval an educational course on forensic evaluator ethics, or on matters related to the violation(s) charged in the accusation, or both. Said course(s) shall be successfully completed by Respondent (enter time for completion), and in any event no later than during the first year of probation. Respondent shall provide theAdministrative Director or its designee with proof of attendance at such course(s).

Completion of any such course required as a term of probation shall be in addition to the continuing medical education requirements for reappointment as a Qualified Medical Evaluator.

Following completion of each course ordered as a term of probation, the Administrative Director or his/her designee may administer an examination to test Respondent's knowledge of the course(s).

18. Clinical Training

Within sixty (60) days of the effective date of this decision, Respondent shall submit to the Administrative Director for its prior approval a clinical training or educational program. The exact number of hours and the specific content of the program shall be determined by the Administrative Director or his/her designee and shall be related to the violations charged in the accusation. Respondent shall successfully complete the training program and may be required to pass an examination administered by the Administrative Director or its designee

related to the program's contents prior to performing work as a Qualified Medical Evaluator or Agreed Medical Evaluator.

19. Oral, Clinical or Written Exam

Within sixty (60) days of the effective date of this decision, (or upon completion of the required education or ethics course) (or upon completion of the required clinical training program), Respondent shall take and pass a(n) (oral, clinical and/or written) examination to be administered by the Administrative Director or his/her designee. If Respondent fails this examination, Respondent must wait three months between reexaminations, except that after three failures Respondent must wait one year to take each necessary reexamination thereafter. Respondent shall pay the costs of all examinations.

(Use either of the following paragraphs with the above paragraph):

Option #1: Condition Precedent

Respondent shall not perform any functions as a Qualified Medical Evaluator or Agreed Medical Evaluator until Respondent has passed this examination and has been so notified by the Administrative Director in writing.

Option #2: Condition Subsequent

If Respondent fails to take and pass the first examination,Respondent shall cease performing any functions as a Qualified Medical Evaluator or an Agreed Medical Evaluator until this examination has been successfully passed and Respondent has been so notified by the Administrative Director in writing.

20. Restitution

Respondent shall provide restitution to _____in the amount of $ _____ prior to completion of the first year of probation.

21. Third Party Presence-Sexual Transgressions

During probation, Respondent shall have a third party present while examining, evaluating or treating (enter appropriate: male/female/minor) injured workers. Respondent shall, within fifteen (15) days of the effective date of the decision, submit to the Administrative Director or his/her designee, for his/her approval, the name(s), business and home phone number(s), and business address, of the persons who will act as the third party present. Respondent shall execute a written release authorizing the designated third party(s) to divulge any information that the Administrative Director may request during interviews by the probation monitor on a periodic basis.

22. Supervised Structured Practice

Respondent is prohibited from engaging in solo practice. Within thirty (30) days of the effective date of this

decision, Respondent shall submit to the Administrative Director and receive his/her prior approval for a plan of practice limited to a supervised, structured environment in which respondent's activities will be overseen and supervised by another QME, who shall provide periodic reports to the Administrative Director.

23. Monitored Practice

Within thirty (30) days of the effective date of this decision, Respondent shall submit to the Administrative Director and receive his/her prior approval for a plan of practice in which Respondent's activities as a QME or AME will be monitored by another QME, who shall provide periodic reports to the Administrative Director or his/her designee.

If the monitor resigns or is no longer available, Respondent shall, within five (5) days, provide the Administrative Director or his/her designee the name, address and phone number of a new monitor, for the Administrative Director's approval.

Respondent shall execute a written release authorizing the designated third party(s) to divulge any information that the Administrative Director may request during interviews by the probation monitor on a periodic basis.

24. Psychiatric Evaluation

Within thirty (30) days of the effective date of this decision, and on a periodic basis thereafter as may be required by the Administrative Director or his/her designee, Respondent shall undergo a psychiatric evaluation by a psychiatrist/psychologist appointed by the Administrative Director. The appointed evaluator shall furnish a report to the Administrative Director or his/her designee.

If Respondent is required by the Administrative Director or his/her designee to undergo psychiatric treatment, Respondent shall within thirty (30) days of the requirement notice, submit to the Administrative Director for his/her prior approval the name and qualifications of a psychotherapist of Respondent's choice. Upon approval of the treating psychotherapist, Respondent shall undergo and continue psychiatric treatment until further notice from the Administrative Director. Respondent shall have the treating psychotherapist submit quarterly status reports to the Administrative Director.

(Optional)

Respondent shall not perform any function as a Qualified Medical Evaluator or an Agreed Medical Evaluator until notified by the Administrative Director of his/her determination that Respondent is mentally fit to resume such forensic practice.

25. Psychiatric Treatment

Within sixty (60) days of the effective date of this decision, Respondent shall submit to the Administrative Director for his/her prior approval the name and qualifications of a psychotherapist of Respondent's choice. Upon approval, Respondent shall undergo and continue treatment until his or her treating psychotherapist (i.e.

psychiatrist, psychologist, other licensed mental health practitioner) deems that no further psychiatric treatment is necessary. Respondent shall have the treating psychotherapist submit quarterly status reports to the Administrative Director. The Administrative Director may require Respondent to undergo psychiatric evaluations by an Administrative Director-appointed psychiatrist/psychologist.

(Note: This condition is for those cases where the evidence demonstrated that the respondent has had impairment [i.e. impairment by mental illness, alcohol abuse and drug self abuse] related to the violations but is not at present a danger to his/her patients.)

26. Medical Evaluation

Within thirty (30) days of the effective date of this decision, and on a periodic basis thereafter as may be required by the Administrative Director or his/her designee, Respondent shall undergo a medical evaluation by an Administrative Director appointed physician who shall furnish a medical report to the Administrative Director or his/her designee.

If Respondent is required by the Administrative Director or his/her designee to undergo medical treatment, Respondent shall within thirty (30) days of the requirement notice, submit to the Administrative Director for his/her prior approval the name and qualifications of a physician of Respondent's choice. Upon approval of the treating physician, Respondent shall undergo and continue medical treatment until further notice from the Administrative Director. Respondent shall have the treating physician submit quarterly reports to the Administrative Director.

(Optional)

Respondent shall not perform any functions as a Qualified Medical Evaluator or an Agreed Medical Evaluator until notified by the Administrative Director of his/her determination that Respondent is medically fit to resume forensic practice safely.

(Note: This condition is for those cases where the evidence demonstrates that medical illness or disability was a contributing cause of the violations.)

27. Medical Treatment

Within sixty (60) days of the effective date of this decision, Respondent shall submit to the Administrative Director for his/her prior approval the name and qualifications of a physician of Respondent's choice. Upon approval, Respondent shall undergo and continue treatment until the Administrative Director deems that no further medical treatment is necessary. Respondent shall have the treating physician submit quarterly reports to a physician appointed by the Administrative Director to evaluate Respondent. Such reports shall indicate whether Respondent is capable of practicing forensic medicine safely. The Administrative Director may require Respondent to undergo periodic medical evaluations by an Administrative Director appointed physician. The Respondent shall pay the costs of all required evaluations.

(Note: This condition is for those cases where there is evidence that medical illness or disability was a contributing cause of the violations but the Respondent is not at present a danger to his/her patients.)

28. Biological Fluid Testing

Respondent shall immediately submit to biological fluid testing, at Respondent's cost, upon the request of the Administrative Director or his/her designee.

29. Diversion Program

Within thirty (30) days from the effective date of this decision, Respondent shall enroll and participate in a diversion program designated by the Administrative Director or his/her designee, until the Administrative Director determines that further treatment and rehabilitation is no longer necessary. Quitting the program without permission or being expelled for cause shall constitute a violation of probation by Respondent.

30. Drugs-Abstain from Use

Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Business and Professions Code, or any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to respondent for a bona fide illness or condition by another practitioner.

31. Controlled Drugs-Maintain Record

Respondent shall maintain a record of all controlled substances prescribed, dispensed or administered by Respondent during probation, showing all the following: 1) the name and address of patient, 2) the date, 3) the character and quantity of controlled substances involved, and 4) the indications and diagnoses for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order, and shall make them available for inspection and copying by the Administrative Director or his/her designees, upon request.

32. Alcohol-Abstain from Use

Respondent shall abstain completely from the use of alcoholic beverages.

33. Notation of Probationary QME Status

Upon the effective date of this decision, the Administrative Director shall make a notation on each letter sent to an unrepresented injured worker, which lists Respondent's name on a panel of QMEs, indicating that Respondent is currently on probation as a QME. Administrative Director also shall make a notation next to Respondent's name wherever it appears in each QME roster issued during the period in which Respondent is on probation on the date the roster is issued. Respondent shall answer truthfully any questions from injured workers or other parties about Respondent's probationary QME status.

34. Submission of Reports to the Administrative Director

Respondent shall submit to the Administrative Director copies of the next five medical/legal reports written by Respondent after the effective date of this decision, in the capacity of a Qualified Medical Evaluator. Respondent shall submit a copy of each such report to the Administrative Director probation monitor within 10 working days of forwarding the report to any party in the case.

35. Use of Terminology Regarding Area of Practice or Specialty

Respondent shall ensure all statements regarding Respondent's professional training and area of practice, appearing on letterhead, advertising, business cards, web sites and other public communications, conform to the provisions of Business and Professions Code 651. Further, Respondent shall refrain from using terms, including (state specific terms or phrases used which resulted in discipline). Respondent further agrees to (add specific terms as applicable to case).

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Section 139.2, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

2. Change without regulatory effect amending section filed 10-29-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 44). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

3. Amendment of section heading, section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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TITLE 8. INDUSTRIAL RELATIONS
DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR

Article 7. Practice Parameters for the Treatment of Common Industrial Injuries
New query

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§70. Treatment Guideline for Low Back Problems. [Reserved]

Note: Authority cited: Section 139(e)(8), Labor Code. Reference: Section 139(e)(8) Labor Code.

HISTORY

1. Editorial correction changing placement of article 7 heading (Register 97, No. 23).

2. New section filed 6-3-97; operative 7-3-97 (Register 97, No. 23).

3. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

4. Change without regulatory effect amending section filed 7-12-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 28). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

5. Repealer of article 7 (sections 70-77) and section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
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Article 7. Practice Parameters for the Treatment of Common Industrial Injuries
New query

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§71. Treatment Guideline for Industrial Neck Injuries. [Reserved]

Note: Authority cited: Section 139(e)(8), Labor Code. Reference: Section 139(e)(8), Labor Code.

HISTORY

1. New section filed 7-18-97; operative 8-17-97 (Register 97, No. 29).

2. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Change without regulatory effect amending section filed 7-12-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 28). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

Repealer filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Chapter 1. Industrial Medical Council Article 7. Practice Parameters for the Treatment of Common Industrial Injuries

New query

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§72. Treatment Guideline for Occupational Asthma. [Reserved]

Note: Authority cited: Section 139(e)(8), Labor Code. Reference: Section 139(e)(8), Labor Code.

HISTORY

1. New section filed 9-18-95; operative 10-18-95 (Register 95, No. 38).

2. Change without regulatory effect amending section heading and section filed 9-25-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 39).

3. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

4. Change without regulatory effect amending section filed 7-12-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 28). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

5. Repealer filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Chapter 1. Industrial Medical Council Article 7. Practice Parameters for the Treatment of Common Industrial Injuries

New query

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§73. Treatment Guideline for Contact Dermatitis. [Reserved]

Note: Authority cited: Section 139(e)(8), Labor Code. Reference: Section 139(e)(8), Labor Code.

HISTORY

1. New section filed 9-18-95; operative 10-18-95 (Register 95, No. 38).

2. Change without regulatory effect amending section heading and section filed 9-25-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 39).

3. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

4. Change without regulatory effect amending section filed 7-12-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 28). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

5. Repealer filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 7. Practice Parameters for the Treatment of Common Industrial Injuries

New query

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§74. Treatment Guideline for Post-Traumatic Stress Disorder. [Reserved]

Note: Authority cited: Section 139(e)(8), Labor Code. Reference: Section 139 and 139.2, Labor Code.

HISTORY

1. New section filed 1-24-97; operative 2-23-97 (Register 97, No. 4).

2. Change without regulatory effect amending section filed 7-12-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 28). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

3. Repealer filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 7. Practice Parameters for the Treatment of Common Industrial Injuries

New query

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§75. Treatment Guidelines for Shoulder Problems. [Reserved]

Note: Authority cited: Section 139(e)(8), Labor Code. Reference: Section 139(e)(8), Labor Code.

HISTORY

1. New section filed 7-16-97; operative 8-15-97 (Register 97, No. 29).
2. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Change without regulatory effect amending section filed 7-12-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 28). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

4. Repealer filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 7. Practice Parameters for the Treatment of Common Industrial Injuries

New query

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§76. Treatment Guideline for Knee Problems. [Reserved]

Note: Authority cited: Section 139(e)(8), Labor Code. Reference: Section 139(e)(8), Labor Code.

HISTORY

1. New article 7 (section 76) and section filed 5-13-97; operative 6-12-97 (Register 97, No. 20).

2. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Change without regulatory effect amending section filed 7-12-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 28). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

4. Repealer filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Chapter 1. Industrial Medical CouncilArticle 7. Practice Parameters for the Treatment of Common Industrial Injuries

New query

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§76.5. Treatment Guideline for Elbow Problems. [Reserved]

Note: Authority cited: Section 139(e)(8), Labor Code. Reference: Section 139(e)(8), Labor Code.

HISTORY

1. New section filed 7-17-97; operative 8-16-97 (Register 97, No. 29).
2. Amendment filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. Change without regulatory effect amending section filed 7-12-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 28). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

4. Repealer filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 7. Practice Parameters for the Treatment of Common Industrial Injuries

New query

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§77. Treatment Guideline for Problems of the Hand and Wrist. [Reserved]

Note: Authority cited: Section 139(e)(8), Labor Code. Reference: Section 139(e)(8), Labor Code.

HISTORY

1. New section filed 7-18-97; operative 8-17-97 (Register 97, No. 29).
2. Change without regulatory effect amending section filed 7-12-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 28). Pursuant to this filing, material adopted pursuant to the Administrative Procedure Act that had previously been incorporated by reference in the California Code of Regulations was instead printed in full in the California Code of Regulations.

3. Repealer filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 10. QME Application Forms

New query

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§100. The Application for Appointment as Qualified Medical Evaluator Form.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4061.5, 4062, 4062.1 and 4062.2, Labor Code; Sections 1798 et seq., Civil Code, and Sections 6250 et seq., Government Code.

HISTORY

1. Renumbering of former article 10 to new article 15, new article 10 (sections 100-104) and new section filed 4-4-2000; operative 5-14-2000 (Register 2000, No. 15). For prior history see Register 94, No. 31.

2. Amendment filed 8-23-2001; operative 8-23-2001 pursuant to GovernmentCode section 11343.4 (Register 2001, No. 34).

3. Change without regulatory effect amending section filed 5-2-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 18).

4. Change without regulatory effect amending section filed 1-27-2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 4).

5. Repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 10. QME Application Forms

New query

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§101. The Alien Application Form. [Reserved]

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).
For prior history see Register 94, No. 31.

2. Repealer filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 10. QME Application Forms

New query

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§102. The Application for QME Competency Examination Form.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Section 139.2, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).
For prior history see Register 94, No. 31.

2. Change without regulatory effect amending section filed 1-27-2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 4).

3. Repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 10. QME Application Forms

New query

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§103. The QME Fee Assessment Form.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Section 139.2, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).
For prior history see Register 94, No. 31.

2. Change without regulatory effect amending section filed 6-27-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 26).

3. Repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 10. QME Application Forms

New query

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§104. The Reappointment Application as Qualified Medical Evaluator Form.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4061.5, 4062, 4062.1 and 4062.2, Labor Code; Sections 1798 et seq., Civil Code, and Sections 6250 et seq., Government Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).
For prior history see Register 94, No. 31.

2. Amendment filed 9-6-2001; operative 10-6-2001 (Register 2001, No. 36).

3. Repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 10.5. QME Process Forms

New query

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§105. The Request for Qualified Medical Evaluator Panel-Unrepresented Form and Attachment to Form 105 (How to Request a QME If You Do Not Have an Attorney).

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4061.5, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New article 10.5 (sections 105-117) and new section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15). For prior history see Register 94, No. 31.

2. Amendment of section heading, repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 10.5 QME Process Forms
New query

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§106. The Request for Qualified Medical Evaluator Panel-Represented Form and Attachement to Form 106 (How to Request a QME in a Represented Case).

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).
For prior history see Register 94, No. 31.

2. Change without regulatory effect amending section filed 5-2-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 18).

3. Amendment of section heading, repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 10.5 QME Process Forms

New query

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§107. The Qualified Medical Evaluator Panel Selection Form.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).For prior history see Register 94, No. 31.

2. Repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 10.5. QME Process Forms
New query

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§108 .The Qualified Medical Evaluator Panel Selection Instruction Form.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).
For prior history see Register 94, No. 31.

2. Amendment of section heading, repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§109. The Qualified Medical Evaluator Notice of Unavailability Form.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).
For prior history see Register 94, No. 31.

2. Amendment of section heading, repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§110. The Appointment Notification Form.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).
For prior history see Register 94, No. 31.

2. Repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§111. The Qualified or Agreed Medical Evaluator Findings Summary Form.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064, 4067, and 4660-4664, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

2. Amendment of section heading, repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§112. The QME/AME Time Frame Extension Request Form.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

2. Amendment of section heading, repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§113. Notice of Denial of Request for Time Extension Form.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

2. Amendment of section heading, repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§114. The Denial of Time Extension Form. [Reserved]

Note: Authority cited: Sections 139 and 139.2, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062 and 4062.5, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).
2. Repealer filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§115. The Notice of Late Qualified Medical Evaluator Report Form. [Reserved]

Note: Authority cited: Sections 139 and 139.2, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062 and 4062.5, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

2. Repealer filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§116. Notice of Late QME/AME Report-No Extension Requested Form.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

2. Amendment of section heading, repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§117. Qualified Medical Evaluator Course Evaluation Form.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

2. Change without regulatory effect amending section filed 5-2-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 18).

3. Amendment of section heading, repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§118. Application for Accreditation or Re-Accreditation As Education Provider.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 10-16-2000 as an emergency; operative 1-1-2001 (Register 2000, No. 42). A Certificate of Compliance must be transmitted to OAL by 5-1-2001 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 5-2-2001 as an emergency; operative 5-2-2001 (Register 2001, No. 18). A Certificate of Compliance must be transmitted to OAL by 8-30-2001 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 5-2-2001 order, including further amendment of section, transmitted to OAL 7-12-2001 and filed 8-23-2001 (Register 2001, No. 34).

4. Repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§119. Faculty Disclosure of Commercial Interest.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 10-16-2000 as an emergency; operative 1-1-2001 (Register 2000, No. 42). A Certificate of Compliance must be transmitted to OAL by 5-1-2001 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 5-2-2001 as an emergency; operative 5-2-2001 (Register 2001, No. 18). A Certificate of Compliance must be transmitted to OAL by 8-30-2001 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 5-2-2001 order, including further amendment of section, transmitted to OAL 7-12-2001 and filed 8-23 2001 (Register 2001, No. 34).

4. Repealer and new section and new Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§120. Voluntary Directive for Alternate Service of Medical-Legal Evaluation Report on Disputed Injury to Psyche.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§120. Voluntary Directive for Alternate Service of Medical-Legal Evaluation Report on Disputed Injury to Psyche.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§121. Declaration Regarding Protection of Mental Health Record.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§122. AME or QME Declaration of Service of Medical-Legal Report.

NOTE: Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§123. 124. Specified Financial Interest Attachment to QME Forms 100, 103 or 104 ("SFI Form 124").

Any physician who files a QME Form 100 (Application for Appointment), 103 (QME Fee Assessment Form) or 104 (Reappointment Application) with the Administrative Director also shall complete the QME SFI Form 124, in order to disclose specified financial interests that may affect the fairness of QME panels, and append it to the form 100, 103 or 104 being submitted when the form is filed.

NOTE:

Form is available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.

Note: Authority cited: Sections 53, 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, Labor Code.

HISTORY

1. New section filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§149. Definitions. [Renumbered]

Note: Authority cited: Section 139, Labor Code. Reference: Sections 139, 139.2 and 4628, Labor Code.

HISTORY

1. New article 4.5 and section filed 7-8-94; operative 8-8-94 (Register 94, No. 27).

2. Change without regulatory effect relocating article 4.5 heading and renumbering former section 149 to new section 49 filed 8-31-94 pursuant to section 100, title 1, California Code of Regulations (Register 94, No.35).

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§149.2. Neuromusculoskeletal Evaluation. [Renumbered]

Note: Authority cited: Sections 139 and 139.2(j), Labor Code. Reference: Sections 139, 139.2 and 4628, Labor Code.

HISTORY

1. New section filed 7-8-94; operative 8-8-94 (Register 94, No. 27).

2. Change without regulatory effect renumbering former section 149.2 to new section 49.2 filed 8-31-94 pursuant to section 100, title 1, California Codeof Regulations (Register 94, No. 35).

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§149.4. Cardiovascular Evaluation. [Renumbered]

Note: Authority cited: Sections 139 and 139.2(j), Labor Code. Reference: Sections 139, 139.2 and 4628, Labor Code.

HISTORY

1. New section filed 7-8-94; operative 8-8-94 (Register 94, No. 27).

2. Change without regulatory effect renumbering former section 149.4 to new section 49.4 filed 8-31-94 pursuant to section 100, title 1, California Codeof Regulations (Register 94, No. 35).

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§149.6. Pulmonary Evaluation. [Renumbered]

Note: Authority cited: Sections 139 and 139.2(j), Labor Code. Reference: Sections 139, 139.2 and 4628, Labor Code.

HISTORY

1. New section filed 7-8-94; operative 8-8-94 (Register 94, No. 27).

2. Change without regulatory effect renumbering former section 149.6 to new section 49.6 filed 8-31-94 pursuant to section 100, title 1, California Codeof Regulations (Register 94, No. 35).

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§149.8. Psychiatric evaluation. [Renumbered]

Note: Authority cited: Sections 139 and 139.2(j), Labor Code. Reference: Sections 139, 139.2 and 4628, Labor Code.

HISTORY

1. New section filed 7-8-94; operative 8-8-94 (Register 94, No. 27).
2. Change without regulatory effect renumbering former section 149.8 to new section 49.8 filed 8-31-94 pursuant to section 100, title 1, California Codeof Regulations (Register 94, No. 35).

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§149.9. Other evaluation. [Renumbered]

NOTE: Authority cited: Sections 139 and 139.2(j), Labor Code. Reference: Sections 139, 139.2 and 4628, Labor Code.

HISTORY

1. New section filed 7-8-94; operative 8-8-94 (Register 94, No. 27).

2. Change without regulatory effect renumbering former section 149.9 to new section 49.9 filed 8-31-94 pursuant to section 100, title 1, California Code of Regulations (Register 94, No. 35).

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§150. Definitions.

As used in this Article:

(a) Administrative Director - means the Administrative Director of the Division of Workers' Compensation of the State of California, Department of Industrial Relations, and includes his or her designee.

(b) Advertising copy - includes any "public communication" as defined in Business and Professions Code Section 651, or any other communication of any message in any form or medium regarding the availability for professional employment of any physician, which is made by or on behalf of any physician to the general public or any substantial portion thereof.

Advertising concerning medical services regarding industrial injuries or illnesses which benefits any physician, and which is placed by any medical clinic, medical service organization or other non-physician third party shall be deemed advertising copy subject to these regulations.

(c) Medical Board - means the Medical Board of California as established in Business and Professions Code Section 2001.

(d) Medical Director - means the physician appointed pursuant to Labor Code Section 122 or such person as he or she may designate.

(e) Physician - has the meaning defined in Labor Code Section 3209.3.

(f) QME - means a Qualified Medical Evaluator as defined in Labor Code Section 139.2.
Note: Authority cited: Sections 133, 139.4, 139.45 and 5307.3, Labor Code. Reference: Sections 139.2, 139.4 and 139.45, Labor Code.

HISTORY

1. New article 10 and section filed 3-31-93; operative 4-30-93 (Register 93, No. 14).

2. Renumbering of article 10 to article 15 filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).

3. New subsection (a), repealer of subsection (b), subsection relettering and amendment of Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No.
3).

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§151. Filing of Documents.

Any document filed under these regulations shall be deemed filed on the date when it is received by the Administrative Director.

Note: Authority cited: Sections 133, 139.4, 139.45 and 5307.3, Labor Code. Reference: Sections 133, 139.4 and 139.45, Labor Code.

HISTORY

1. New section filed 3-31-93; operative 4-30-93 (Register 93, No. 14).

2. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§152. Statement of Intent.

Nothing in these regulations is intended to alter the interpretation or application of Business and Professions Code section 651. These regulations are promulgated under the authority of Labor Code sections 139.4 and 139.45 and are intended to reflect the Administrative Director's understanding of the Legislature's intent that the Administrative Director apply a higher and independent standard, pursuant to those Sections, to physician advertising which relates to industrial injuries or illnesses.

Note: Authority cited: Sections 133, 139.4, 139.45 and 5307.3, Labor Code. Reference: Sections 28, 139.4 and 139.45, Labor Code.

HISTORY

1. New section filed 3-31-93; operative 4-30-93 (Register 93, No. 14).

2. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§153. False or Misleading Advertising Copy Prohibited.

No physician subject to these regulations, or any person acting on his or her behalf or for his or her benefit, shall use, cause to be used, or allow to be used:

(a) Any advertising copy which, through endorsements, testimonials or other representations, makes or implies any guarantee, warranty, or prediction that is intended, or is likely, to create a false or unjustified expectation of favorable results concerning the outcome of the employment of the physician.

(b) Any advertising copy which by use of a firm name, trade name, fictitious business name, or other professional designation states or implies a relationship between any physician in private practice and any governmental agency or entity, with the exception that, as provided in section 154 below, a physician currently or previously certified by the Administrative Director as a Qualified Medical Evaluator may state this fact in advertising copy, a curriculum vitae or in descriptive text, only for the period of time that is true and correct.

(c) Any advertising copy which states or implies that a medical-legal report written by any physician, or group or association of physicians enjoys any special degree of credibility by any workers' compensation judge or judges.

(d) Any advertising copy which advises or recommends the securing of any medical-legal examination, or which suggests that a tactical advantage may be secured by obtaining any medical-legal evaluation.

(e) Any advertising copy which contains the phrase "Qualified Medical Evaluator" or the designation "QME" unless such phrase is used to identify individual physicians who are currently certified as QMEs by the Administrative Director in accordance with Labor Code section 139.2.

(f) Any advertising copy which contains a firm name, trade name, or fictitious business name which contains the phrases "Qualified Medical Evaluator," "Qualified Medical Examiner", "Agreed Medical Evaluator", "Agreed Medical Examiner", "Independent Medical Examiner" , "Independent Medical Evaluator" or the designations "QME", "AME" or "IME."

(g) Any advertising copy which states or implies that any physician has an ongoing appointment, title or professional status as an "Agreed Medical Examiner," "Agreed Medical Evaluator", "Independent Medical Examiner," "AME," or "IME."

(h) Any advertising copy which states or implies that the physician is currently an "Agreed Medical Examiner" or

"Independent Medical Examiner" in the California Workers' Compensation system.

Note: Authority cited: Sections 133, 139.4, 139.45 and 5307.3, Labor Code. Reference: Sections 28, 139.2, 139.4 and 139.45, Labor Code.

HISTORY

1. New section filed 3-31-93; operative 4-30-93 (Register 93, No. 14).

2. Amendment of subsections (b), (e) and (f), new subsection (h) and amendment of Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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§154. Permissible Advertising Content.

(a) A physician subject to these regulations, or any person acting on his or her behalf, may use, disseminate, or cause to be disseminated to the public, or any portion of the public, advertising copy which relates to any industrial injury or illness which accurately states:

(1) The name of each physician affiliated with or participating in the physician's practice.

(2) The address, telephone number and business hours of the office or offices.

(3) The areas of practice each physician engages in.

(4) An individual physician's appointment as a QME. A physician who is not currently certified by the Administrative Director as a Qualified Medical Evaluator may, in a curriculum vitae or descriptive text, state any periods in the past during which the physician was certified as a Qualified Medical Evaluator.

(5) A statement that the physician is Board Certified or limits his or her practice to specific fields as authorized by Business and Professions Code Section 651. Any statement of Board Certification shall include the name of the certifying board.

(6) Any languages spoken fluently by the physician or his or her staff.

(7) A description of any diagnostic or therapeutic facilities available.

(8) The availability of surgery or hospitalization on a lien basis.

(9) The usual time frame for scheduling appointments or producing medical reports.

(10) That all billings are made in compliance with the Official Medical Fee Schedule promulgated by the Administrative Director.

(11) Biographic information concerning the physician's educational background, internships and residencies, hospital affiliations, professional affiliations and professional publications.

(b) Any physician who wishes to use, disseminate, or cause to be disseminated to the public, or any portion of the public, any advertising copy which relates to any industrial injury or illness which contains any material not specified in subsection (a) above, shall apply in writing to the Administrative Director for approval before using such material. The Administrative Director shall approve all requests which do not contain material which is false or likely to mislead the public with respect to workers' compensation. No advertising copy submitted to the Council pursuant to this subsection shall be used until the Administrative Director has given his/her written approval.

Note: Authority cited: Sections 133, 139.4, 139.45 and 5307.3, Labor Code. Reference: Sections 139.2, 139.4 and 139.45, Labor Code.

HISTORY

1. New section filed 3-31-93; operative 4-30-93 (Register 93, No. 14).

2. Amendment of subsections (a)(4), (a)(10) and (b) and amendment of Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 15. Fraudulent or Misleading Advertising

New query

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§155. Filing of Complaints.

(a) Any person may file a complaint with the Medical Director, alleging that any physician is using advertising copy which violates the provisions of Business and Professions Code Section 651, or the provisions of these regulations.

(b) Complaints filed with the Medical Director shall be in writing and contain the following:

(1) The full name and address of the party filing the complaint.

(2) The full name and address of the physician against whom the complaint is made, or if the complainant is unable to identify the physician using the advertising, as much information as the complainant can provide to assist the Administrative Director in identifying the physician who used the advertisement.

(3) A copy, if available to the complaining party, of the advertising copy against which the complaint is made, or a description of the medium in which the advertising copy appeared. Such description should contain sufficient details regarding the manner and form in which the advertising copy was published to allow a copy of the advertising copy to be obtained by the Administrative Director.

(4) A detailed statement of the grounds on which the advertising copy is alleged to violate Business and Professions Code Section 651 or these regulations.

(5) All complaints filed under this section shall be filed with the Medical Director, at Division of Workers' Compensation, P.O. Box 71010, Attention: Medical Unit, Oakland, CA 94612.

(6) Nothing in these regulations shall prevent the Administrative Director or Medical Director from acting independently, and without receipt of a complaint, to initiate an investigation and issue a complaint on the Administrative Director's own motion whenever the Administrative Director or Medical Director has reason to believe that there has been a violation of Business and Professions Code section 651 or these regulations.

Note: Authority cited: Sections 133, 139.4, 139.45 and 5307.3, Labor Code. Reference: Sections 139.4 and 139.45, Labor Code.

HISTORY

1. New section filed 3-31-93; operative 4-30-93 (Register 93, No. 14).

2. Amendment of subsections (b)(2)-(3) and (b)(5)-(6) and amendment of Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 15. Fraudulent or Misleading Advertising
New query

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§156. Council Requests to Review Advertising Copy.

(a) Upon receipt of a complaint under Section 155 of these regulations, the Administrative Director shall serve a written notice of complaint on the physician against whom the complaint was filed. Such notice shall direct the physician to file a copy of his or her advertising with the Medical Director within 15 working days of the date on which the notice was served.

(b) The Medical Director may take such steps as he or she deems necessary to determine whether the complaint has merit.

(1) The Medical Director shall respond to the complaint within fifteen (15) working days of the Administrative Director's receipt of the physician's response and notify the complainant that the Administrative Director:

(A) will investigate the complaint; or

(B) will require additional time to ascertain whether the complaint has merit; or

(C) will refer a copy of the complaint to another agency which also has jurisdiction over the subject matter of the complaint; or

(D) will take no further action on the complaint because the Administrative Director lacks jurisdiction over the person or conduct complained of; or

(E) will take no further action on the complaint because the allegations of the complaint do not warrant further action by the Administrative Director for the reasons stated in the response.

(c) At the time of filing the advertising copy with the Medical Director, the physician shall also file an answer to the complaint, briefly setting forth the grounds on which the physician believes the copy to be in compliance with Business and Professions Code Section 651, and the provisions of these regulations. Nothing contained in the answer shall preclude the right of the physician to present further or different grounds of defense before the Administrative

Director or appropriate licensing board. Upon reviewing the physician's answer, the Medical Director may dismiss or informally resolve the complaint where he or she deems such action appropriate.

(d) The Administrative Director may, without receipt of a complaint, request a physician to provide a copy of any advertising used by that physician for review. Such a request shall be made in writing, and shall be personally served on the physician.

(e) If a physician who has been appointed as a QME fails to deliver a copy of the advertising used to the Administrative Director within fifteen (15) working days of receipt of the notice, the Administrative Director may infer from the failure to comply that the advertising material used by the QME is in violation of Business and Professions Code Section 651, or these regulations. The maximum penalty that the Administrative Director may impose for a finding of violation based solely on the negative inference created by this provision shall be suspension of the physician's appointment as a Qualified Medical Evaluator for a period of six months followed by a period of probation not to exceed one year.

(f) If a non-QME physician fails to deliver a copy of the advertising used to the Administrative Director within fifteen (15) working days of receipt of the request, the Administrative Director shall refer the matter to that physician's licensing board for such proceedings as that board may deem proper.

Note: Authority cited: Sections 133, 139.4, 139.45 and 5307.3, Labor Code. Reference: Sections 139.4 and 139.45, Labor Code.

HISTORY

1. New section filed 3-31-93; operative 4-30-93 (Register 93, No. 14).

2. Amendment of section heading, section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 15. Fraudulent or Misleading Advertising
New query

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§157. Determinations.

(a) If, after reviewing the physician's advertising copy and the physician's answer to the complaint, the Medical Director determines that the advertising copy violates Business and Professions Code section 651, or these regulations and that the physician is currently a Qualified Medical Evaluator, the disciplinary and hearing procedures set forth in sections 60 through 65 of Title 8 of the California Code of Regulations shall apply. The Medical Director shall forward a copy of any final decision of such violations to the physician's licensing board for such proceedings as that board may deem proper.
(b) If the Medical Director determines that the physician subject to the investigation currently is not a QME, the Medical Director shall forward a copy of the preliminary determination, the complaint, and all supporting documentation to the appropriate physician's licensing board for such proceedings as that board may deem proper.
Note: Authority cited: Sections 133, 139.4, 139.45 and 5307.3, Labor Code. Reference: Sections 139.4 and 139.45, Labor Code.

HISTORY

1. New section filed 3-31-93; operative 4-30-93 (Register 93, No. 14).

2. Amendment of subsections (a) and (b), repealer of subsections (c)-(d)(6) and amendment of Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 15. Fraudulent or Misleading Advertising

New query

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§158. Penalties.

(a) A QME who is found to have violated any provision of Business and Professions Code section 651, or these regulations may have his or her QME status terminated, suspended, or placed on probation by the Administrative Director. Any probation imposed may have such conditions as the Administrative Director deems reasonable, including, but not limited to the publication of corrective advertising and the submission of future advertising copy for the Administrative Director's approval before its use.

(b) The Administrative Director shall consider the following factors in determining the appropriate penalty for a violation of Business and Professions Code section 651, or these regulations:

1. the seriousness or materiality of the misrepresentation,

2. whether the physician cooperated with the investigation,

3. whether the violation was a single event, or appeared to be part of a pattern sufficient to demonstrate a business practice,

4. whether the violator has a record of prior discipline by the Administrative Director, Medical Board, or other appropriate licensing board or authority,

5. whether the violator has a record of contempt reprimands or adjudications issued by the Workers' Compensation Appeals Board.

Note: Authority cited: Sections 133, 139.4, 139.45 and 5307.3, Labor Code. Reference: Sections 139.4 and 139.45, Labor Code.

HISTORY

1. New section filed 3-31-93; operative 4-30-93 (Register 93, No. 14).

2. Amendment of subsections (a), (b) and (b)4. and amendment of Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 15. Fraudulent or Misleading Advertising

New query

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§159. Severability.

If any portion of this chapter or the application of any part thereof to any person, individual, party, entity, or circumstance is held invalid, the remainder of the chapter and its application to any other person, individual, party, entity, or circumstance, shall not be affected thereby.

Note: Authority cited: Sections 133, 139.4, 139.45 and 5307.3, Labor Code. Reference: Sections 139.4 and 139.45, Labor Code.

HISTORY

1. New section filed 3-31-93; operative 4-30-93 (Register 93, No. 14).

2. Amendment of Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).

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Article 1. Payment and Conduct of Workers' Compensation Judges (Repealed)

New query

NOTE: Authority cited: Sections 123, 123.5, 123.6 and 133, Labor Code. Reference: Chapters 402 and 414, Statutes of 1980.

HISTORY

1. New Article 1 (Sections 9700-9703) filed 1-16-81; effective thirtieth day thereafter (Register 81, No. 3).

2. Repealer of Article 1 (Sections 9700-9703) filed 8-29-84; effective thirtieth day thereafter (Register 84, No. 35).

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- **§10133.11. Form RU-91 “Description of Employee's Job Duties"** (Repealed)
- **§10133.12 Form RU-94 "Notice of Offer of Modified or Alternative Work"** (Repealed)
- **§10133.13 Form RU-102 "Vocational Rehabilitation Plan"** (Repealed)
- **§10133.14 Form RU-103 "Request for Dispute Resolution"** (Repealed)
- **§10133.15 Form RB-105 "Request for Conclusion of Rehabilitation Benefits"** (Repealed)
- **§10133.16 Form RU-105 "Notice of Termination of Vocational Rehabilitation Services"** (Repealed)
- **§10133.17 Form RB-107 "Statement of Decline of Vocational Rehabilitation Benefits"** (Repealed)
- **§10133.18 Form RU-107 "Employee Statement of Declination of Vocational Rehabilitation Services"** (Repealed)
- **§10133.19 Form RU-107A "Statement of Declination of Vocational Rehabilitation Services"** (Repealed)
- **§10133.20 Form RU-120 "Initial Evaluation Summary"** (Repealed)
- **§10133.21 Form RU-121 "Vocational Rehabilitation Progress Report"** (Repealed)
- **§10133.22 Form RU-122 "Settlement of Prospective Vocational Rehabilitation Services"** (Repealed)

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§10150. Authority.

The Disability Evaluation Unit, under the direction and authority of the Administrative Director, will issue permanent disability ratings as required under this subchapter utilizing the Schedule for Rating Permanent Disabilities adopted by the Administrative Director. The Disability Evaluation Unit will prepare the following kinds of rating determinations:

(a) Formal rating determinations

(b) Summary rating determinations

(c) Consultative rating determinations

(d) Informal rating determinations.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 124, 4061, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section 11351.

2. Amendment of subchapter 1.6 heading filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

3. Amendment of section heading, section and Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 12-31-2004 order transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§10150. Disability Evaluation Unit.

The Disability Evaluation Unit, under the direction and authority of the administrative director, will issue permanent disability ratings as required under this subchapter utilizing the Schedule for Rating Permanent Disabilities adopted by the administrative director. The Disability Evaluation Unit will prepare the following kinds of rating determinations:

(a) Formal rating determinations

(b) Summary rating determinations
(c) Consultative rating determinations

(d) Informal rating determinations.

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 124, 4061, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section11351.

2. Amendment of subchapter 1.6 heading filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section11351 (Register 96, No. 52).

3. Amendment of section heading, section and Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 12-31-2004 order transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

5. Amendment of first paragraph filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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New query

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§10150.1. Signature Disputes and the Signatures of Consultants.

(a) Anyone who disputes the authenticity of any signature must file with the Manager of the Disability Evaluation Unit an objection to the pleading or other document within ten (10) days of the filing of that document. The objection shall contain a complete explanation of the basis for the objection.

(b) The filing of a document, signed with a "/s/ name" or an electronic image of the signature filed with the login and password of the Division of Workers' Compensation consultant assigned to the case shall constitute an original signature for all purposes.

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 124, 4061, 4062, 4062.1, 4062.2, 4062.5, 4064, 4067, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10150.3. Disability Evaluation Unit File Retention.

(a) Following a period of fifty (50) years after the filing of a document used to open a case or file, the Division of Workers' Compensation may destroy the electronic and/or paper file in each case maintained by the Disability Evaluation Unit.

(b) The Division of Workers' Compensation, at any time, may convert a paper file to an electronic file. The Division of Workers' Compensation shall inform the parties when a paper file is converted. If a paper case file has been converted to electronic form, the paper case file may be destroyed no less than 30 business days after the parties have been informed of the conversion.

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 124, 4061, 4062, 4062.1, 4062.2, 4062.5, 4064, 4067, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§ 10150.4. Misfiled or Misdirected Documents.

(a) A request to move or substitute a corrected document shall be made in conformity with section 10223 of title 8 of the California Code of Regulation, except that a written request to substitute with the proposed document for substitution appended shall be made in lieu of a petition to substitute as allowed under section 10223(b). The authority to approve moving a document from one file to another file shall reside with the Manager of the Disability Evaluation Unit or his or her designee.

(b) If a document is not filed in compliance with sections 10217, 10228 and 10232 of title 8 of the California Code of Regulations and these regulations, the administrative director may in his or her discretion take the actions set forth in section 10222 of title 8 of the California Code of Regulations.

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 124, 4061, 4062, 4062.1, 4062.2, 4062.5, 4064, 4067, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10151. Filing Requirements.

(a) "Electronic Adjudication Management System" or "EAMS" means the computer case management system used by the Division of Workers' Compensation to electronically store and maintain the Division of Workers' Compensation or the appeals board's case files and to perform other case management functions.

(b) All forms or correspondence submitted to the Disability Evaluation Unit shall be stored in the EAMS:

(1) Except for documents or forms which open a Disability Evaluation Unit file, all documents and forms shall contain a case number assigned by the Division of Workers' Compensation. The case number shall be preceded by the prefix "DEU". Case opening document shall be assigned a case number by the Division of Workers' Compensation after filing. Documents or forms filed without a case number will be returned to the sender with instructions for proper filing.

(2) All documents presented for filing shall conform to the requirements of sections 10217, 10228 and 10232 of title 8 of the California Code of Regulations.

(3) All filed paper documents and forms shall be scanned into the EAMS and then will be destroyed. A properly filed paper document or form shall be deemed a legal filing for all purposes.

(4) The service of all documents and forms shall conform to the receiving party's designated preferred method of service described in section of 10218 of title 8 of the California Code of Regulation.

Note: Authority cited: Sections 133, 4061, 4660, 5307.3 and 5307.4, Labor Code. Reference: Sections 124 and 4061, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47). For prior history, see Register 2005, No. 23.

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New query

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§10151.1. Electronic Filing Exemption.

If a document is filed with EAMS as part of the electronic filing trial, that document does not need to be filed in compliance with sections 10228 and 10232 of title 8 of the California Code of Regulation.

Note: Authority cited: Sections 111, 133, 5307.3 and 5307.4, Labor Code. Reference: Sections 124 and 4061, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10152. Disability, When Considered Permanent.

A disability is considered permanent when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment.

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 124, 4061, 4062, 4062.01, 4062.1, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section11351.

2. Amendment of section and Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 12-31-2004 order transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§10154. Permanent Disability Rating Determinations, Kinds.

NOTE

Authority cited: Sections 133, 5307.3 and 5307.4, Labor Code. Reference: Sections 124. 4061, 5452, 5701 and 5703.5, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section 11351.

2. New subsection (d) filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

3. Repealer filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 12-31-2004 order transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§10156. Formal Rating Determinations.

A formal rating determination will be prepared by the Disability Evaluation Unit when requested by the Appeals Board or a Workers' Compensation Judge on a form specified for that purpose by the Administrative Director. The form will provide for a description of the disability to be rated, the occupation of the injured employee, the employee's age at the time of injury, the date of injury, the formula used, and a notice of submission in accordance with Appeals Board Rules of Practice and Procedure.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 124, 4061, 4660, 4662, 4663, 4664 and 5701, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section 11351.

2. Amendment of section and Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 12-31-2004 order transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§10158. Formal Rating Determinations As Evidence.

Formal rating determinations prepared by disability evaluators shall be deemed to constitute evidence only as to the relation between the disability or impairment standard(s) described and the percentage of permanent disability.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 124, 4061, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section 11351.

2. Amendment of section and Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 12-31-2004 order transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§10160. 10160. Summary Rating Determinations, Comprehensive Medical Evaluation of Unrepresented Employee.

(a) The Disability Evaluation Unit will prepare a summary rating determination upon receipt of a properly prepared request. A properly prepared request shall consist of:

(1) A completed Request for Summary Rating Determination, DWC AD Form 101 (DEU);

(2) A completed Employee's Disability Questionnaire, DWC AD Form 100 (DEU);

(3) A comprehensive medical evaluation of an unrepresented employee from a Qualified Medical Evaluator.

(b) The insurance carrier or self-insured employer shall provide the employee with an Employee's Disability Questionnaire prior to the appointment scheduled with the Qualified Medical Evaluator. The employee will be instructed in the form and manner prescribed by the administrative director to complete the questionnaire and provide it to the Qualified Evaluator at the time of the examination.

(c) The insurance carrier, self-insured employer or injured worker shall complete a Request for Summary Rating Determination of Qualified Medical Evaluator's Report, a copy of which shall be served on the opposing party. The requesting party shall send the request, including proof of service of the request on the opposing party, to the Qualified Medical Evaluator together with all medical reports and medical records relating to the case prior to the scheduled examination with the Qualified Medical Evaluator. The request shall include the appropriate address of the Disability Evaluation Unit. A listing of all of the offices of the Disability Evaluation Unit, with each office's area of jurisdiction, will be provided, upon request, by any office of the Disability Evaluation Unit or any Information and Assistance Office.

(d) When a summary rating determination has been requested, the Qualified Medical Evaluator shall submit all of the following documents to the Disability Evaluation Unit at the location indicated on the DWC AD Form 101 (DEU) and shall concurrently serve copies on the employee and claims administrator:

(1) Request for Summary Rating Determination of Qualified Medical Evaluator's Report as a cover sheet to the evaluation report;

(2) Employee's Disability Questionnaire;

(3) Comprehensive medical evaluation by the Qualified Medical Evaluator, including the Qualified Medical Evaluator's Findings Summary Form (QME Form 111).

(4) A document cover sheet and separator sheet pursuant to section 10232 (b) of title 8 of the California Code of Regulation, which shall only be served on the Disability Evaluation Unit.

(e) No request for a summary rating determination shall be considered to be received until the Employee's Disability Questionnaire, the Request for Summary Rating Determination of Qualified Medical Evaluator's Report, and the comprehensive medical evaluation have been received by the office of the Disability Evaluation Unit having jurisdiction over the employee's area of residence. In the event an employee does not have a completed Employee's Disability Questionnaire at the time of his or her appointment with a Qualified Medical Evaluator, the medical evaluator shall provide this form to the employee for completion prior to the evaluation. Any requests received on or after April 1, 1994 without all the required documents will be returned to the sender.

(f) Any request for the rating of a supplemental comprehensive medical evaluation report shall be made no later than twenty days from the receipt of the report and shall be accompanied by a copy of the correspondence to the evaluator soliciting the supplemental evaluation, together with proof of service of the correspondence on the opposing party.

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 124, 4061, 4062, 4062.01, 4062.1, 4062.2, 4062.5, 4064, 4067, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section11351.

2. Amendment of section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

3. Amendment of section heading and text filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section11351 (Register 95, No. 8).

4. Amendment of subsections (c)-(d) and (f) and amendment of Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

5. Certificate of Compliance as to 12-31-2004 order, including amendment of subsections (a)(2), (b), (d) and (e), transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

6. Amendment filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10160.1. Summary Rating Determinations, Report of Primary Treating Physician for Unrepresented Employee.

(a) For injuries on or after January 1, 1994, the insurance carrier, self-insured employer or the employee may request a summary rating of the primary treating physician's report prepared in accordance with Section 9785.

(b) The request may be made by completing a Request for Summary Rating Determination of Primary Treating Physician's Report (DWC AD Form 102 (DEU)) and filing the request with the Disability Evaluation Unit together with a copy of the primary treating physician's report, if the report has not already been filed in EAMS.

(c) A filed copy of the request form and a copy of the primary treating physician's report shall be served immediately after filing on the non-requesting party, with a proof of service on the non-requesting party.

Note: Authority cited: Sections 133, 5307.3 and 5307.4, Labor Code. Reference: Sections 124, 4061, 4061.5, 4062, 4062.1, 4062.2, 4062.5, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 8).

2. Amendment filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10160.5. Summary Rating Determinations, Represented Employees.

(a) For injuries on or after January 1, 1991 and before January 1, 1994, the Disability Evaluation Unit will prepare a summary rating determination in cases where the injured worker is represented only if requested by a party. A summary rating determination will be prepared only upon receipt of a properly prepared request. A properly prepared request shall consist of:

(1) A completed Request for Summary Rating Determination DWC AD Form 101 (DEU);

(2) An evaluation by a Qualified Medical Evaluator or Agreed Medical Evaluator.

(b) The requesting party shall complete a Request for Summary Rating Determination of Qualified Medical Evaluator's Report and submit it together with all medical reports and medical records concerning the case to the medical evaluator. The medical evaluator shall send the completed medical evaluation report together with the Request for Summary Rating Determination to the office of the Disability Evaluation Unit designated by the administrative director and specific on the Request for Summary Rating Determination of Qualified Medical Evaluator's Report and shall simultaneously serve the party or parties requesting the evaluation.

(c) Notwithstanding the provisions of subdivision (b), a party may request a summary rating determination following receipt of a medical report prepared by a Qualified Medical Evaluator or Agreed Medical Evaluator on a represented case. The party shall file the Request for Summary Rating Determination of Qualified Medical Evaluator's Report and the medical report with the DEU office designated by the administrative director and shall immediately serve a filed copy of the Summary Rating Determination on the other party.

(d) If a case is settled prior to receipt of a summary rating which has been requested, the requesting party shall notify the DEU office of the settlement.

Note: Authority cited: Sections 133, 5307.3 and 5307.4, Labor Code. Reference: Sections 124, 4061, 4062, 4062.1, 4062.2, 4062.5, 4064 and 4067, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section11351.

2. Amendment of section filed 1-28-94; operative 1-28-94. Submitted to OAL for

printing only pursuant to Government Code section 11351 (Register 94, No. 4).

3. Amendment of section heading and subsections (a)-(c), repealer of subsection (d), subsection relettering, and amendment of redesignated subsection (d) filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 8).

4. Amendment filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10161. Forms.

(a) Employee's Disability Questionnaire (DWC AD Form 100 (DEU)).

(b) Request for Summary Determination of Qualified Medical Evaluator's Report (DWC AD Form 101 (DEU)).

(c) Request for Summary Determination of Primary Treating Physician's Report (DWC AD Form 102 (DEU)).
TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE
Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 124, 4061, 4062, 4062.01, 4062.1, 4062.2, 4062.5, 4064, 4067, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section11351.

2. Repealer and new DEU Form 100 filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

3. Editorial correction restoring inadvertently omitted subsection (b) (Register 95, No. 8).

4. Amendment of subsections (a), (b) and forms 100 and 101; and new subsection (c) and form 102 filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 8).

5. Certificate of Compliance as to 12-31-2004 order, including further amendment of section and forms and amendment of Note, transmitted to OAL 4-29- 2005 and filed 6-10-2005 (Register 2005, No. 23).

6. Amendment of section, including repealer and new DEU Form 100, DEU Form 101 and DEU Form 102, filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§10161.1. Reproduction of Forms.

DEU Forms

The Request for Summary Rating Determination of Qualified Medical Evaluator's Report, the Employee's Disability Questionnaire, and the Request for Summary Rating Determination of the Primary Treating Physician's Report may be reproduced by automated office equipment or other means as long as the printed content and layout of the form are identical to the specified form.

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 124, 4061, 4062, 4062.01, 4062.1, 4062.2, 4062.5, 4064, 4067, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 8).

2. Amendment of section number filed 8-8-95; operative 8-8-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 32).

3. Amendment of section and new Note filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§10162. Summary Rating Determinations, Apportionment.

(a) In cases where the injured worker is not represented and a Qualified Medical Evaluator's formal medical evaluation indicates apportionment of the permanent disability, a summary rating determination will not be made until a workers' compensation administrative law judge has reviewed the medical evaluation to determine if the apportionment is inconsistent with the law. The determination of the workers' compensation administrative law judge will not be admissible in any judicial proceeding.

(b) Upon receipt of a formal medical evaluation which apportions the disability, the Disability Evaluation Unit will transmit the medical evaluation to the presiding workers' compensation administrative law judge of the office of the appeals board designated by the Disability Evaluation Unit, with a request to review the apportionment to determine whether it is inconsistent with the law. The workers' compensation administrative law judge shall make the determination and respond to the Disability Evaluation Unit within 45 days.

(c) If the workers' compensation administrative law judge refers the medical report back to the Qualified Medical Evaluator for correction or clarification, the Qualified Medical Evaluator shall provide a response to the workers' compensation administrative law judge within 30 days of the referral. If no response is received, the workers' compensation administrative law judge shall make a determination whether the apportionment is inconsistent with the law, and a summary rating determination will be made.

(d) In cases where the injured worker is represented and an Agreed Medical Evaluator or Qualified Medical Evaluator apportions the permanent disability, the Disability Evaluation Unit will issue a summary rating determination "Before Apportionment."

Note: Authority cited: Sections 133, 5307.3 and 5307.4, Labor Code. Reference: Sections 124 and 4061, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section11351.

2. Amendment filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10163. Apportionment Referral.

STATE OF CALIFORNIA Department of Industrial Relations Department of Workers' Compensation DISABILITY EVALUATION UNIT

Date: _____ TO: Presiding Workers' Comp. Judge, _____
(Office) _____ FROM: Disability Evaluation Unit, _____
(Office) _____
SUBJECT: DEU File: Employee: QME: Date of Report:
The attached formal medical evaluation report indicates that part or all of the permanent disability may be subject to apportionment pursuant to Labor Code Section 4663 and/or Labor Code Section 4664. Please determine whether the apportionment is inconsistent with the law.
If you believe the apportionment is inconsistent with the law, you may refer the report back to the medical evaluator for correction or clarification. If you receive no response from the medical evaluator within 30 days from your request, please make your determination based on the original report.
After checking the appropriate space, sign and date the bottom of this form and return it with the medical report to the DEU office listed above. Thank you.
The apportionment: IS CONSISTENT _____ or IS NOT CONSISTENT _____with the law.
_____, Workers' Compensation Judge (Signature)
_____ (Date)
NOTE: This memorandum is an administrative document and is not admissible in any judicial proceeding.
DEU Form 105 (Rev 12-04)

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 124, 4061, 4062, 4062.01, 4062.1, 4062.2, 4062.5, 4064, 4067, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section11351.

2. Amendment of section and Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 12-31-2004 order, including further amendment of Note, transmitted to OAL 4-29-

2005 and filed 6-10-2005 (Register 2005, No. 23).

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§10164. Summary Rating Determinations, Reconsideration if Employee is Unrepresented.

(a) Requests for reconsideration of the summary rating determination shall be filed with the administrative director in writing within 30 days of receipt of the summary rating determination. The request shall clearly specify the reasons the summary rating determination should be reconsidered and shall include a proof of service on the other party and any other information necessary to support the request. Reconsideration of a summary rating may be granted by the administrative director for one or more of the following reasons:

(1) the summary rating was incorrectly calculated;

(2) the comprehensive medical evaluation failed to address one or more issues;

(3) the comprehensive medical evaluation failed to completely address one or more issues;

(4) the comprehensive medical evaluation was not prepared in accordance with required procedures, including the procedures of the administrative director promulgated under paragraph (2) or (3) of subdivision (j) of Section 139.2.

Requests for reconsideration which are not based on one of the above reasons will be denied.

(b) The administrative director shall not accept or consider, as a basis for a request for reconsideration, a supplemental or follow-up evaluation which was requested by a party after a summary rating determination has already been issued to the parties.

(c) If the administrative director determines that an additional evaluation from another Qualified Medical Evaluator is necessary, the matter shall be referred to the Medical Director of the Medical Unit for the provision of another Qualified Medical Evaluator.

Note: Authority cited: Sections 133, 5307.3 and 5307.4, Labor Code. Reference: Sections 124 and 4061, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section11351.

2. Amendment of section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

3. Amendment of section heading, repealer of subsection (a), subsection relettering, amendment of redesignated subsection (a), new subsections (a)(1)-(4) and (b) and amendment of subsection (c) filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 8).

4. Amendment filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§ 10165. Service of Summary Rating Determination and Notice of Options Following Permanent Disability Rating.

Within the time specified in Labor Code section 4061(e), the Disability Evaluation Unit shall serve the permanent disability rating determination and the Notice of Options Following Permanent Disability Rating on the employee and employer by the method of service described in section of 10218 of title 8 of the California Code of Regulation.

Note: Authority cited: Sections 133, 5307.3 and 5307.4, Labor Code. Reference: Sections 124 and 4061, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section11351.

2. Amendment filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10165.5. Notice of Options Following Disability Rating (DEU Form 110).

STATE OF CALIFORNIA Department of Industrial Relations Division of Workers' Compensation DISABILITY EVALUATION UNIT

FORMS

NOTICE OF OPTIONS FOLLOWING DISABILITY RATING

This is a disability rating determination (Rating) prepared by the State of California Disability Evaluation Unit within the Division of Workers' Compensation. It describes your percentage of disability. This percentage is based on your limitations as reported by the doctor, your potential loss of future earning capacity, your age, and the type of work you were doing at the time of your injury. If the rating indicates that you have some permanent disability, you should automatically begin to receive permanent disability payments. Payments are made in installments, every two weeks, for the number of weeks shown on the rating, less any permanent disability payments made to you prior to the rating. If the rating is not disputed by you or your employer, you do not have to take any action to receive your benefits. We do want you to know that you may have two options you may want to consider. They are:
1) STIPULATED FINDINGS AND AWARD; 2) COMPROMISE AND RELEASE;

1) STIPULATED FINDINGS AND AWARD

If you and the employer, carrier or agent accept the rating, written agreements may be submitted to the Workers' Compensation Appeals Board (WCAB) requesting that an Award be made without the need for a hearing. We recommend this option when the rating is not disputed, and you have a need for future medical care. A Workers' Compensation Judge will review the stipulations and issue an award.

ADVANTAGES

wA stipulated award is a quick, easy way to settle your case while protecting your rights; wThere is no need to take time off work to go to a hearing; wThe Division of Workers' Compensation will review the settlement to protect your rights at no cost to you, there is no need to hire a lawyer; wIf your condition worsens, you can apply for additional payments anytime within five years from the date of your injury; wIf you need additional medical care or you are to receive a life pension (rating of 70% or more), your rights to future benefits can be fully protected and a judge can enforce the award if there later becomes a problem. wYou may request a lump sum payment of all or part of your permanent disability if you can show a financial need or hardship. However, a Workers' Compensation Judge must first be convinced that it would be in your best interest.

DISADVANTAGES

wYou normally will not receive a lump sum payment, but will receive your benefits in payments every two weeks.

2) COMPROMISE AND RELEASE

A Compromise and Release Agreement is a settlement which usually permanently closes all aspects of a workers' compensation claim except for vocational rehabilitation benefits, including any provision for future medical care.

The Compromise and Release is paid in one lump sum to you. It must be reviewed and approved by a Workers' Compensation Judge.

ADVANTAGES

wYou may receive more money than you would receive under a Stipulated Findings and Award because you are giving up your future rights in exchange for money.

wIf the employer, or insurance company disputes the rating, a Compromise and Release will assure you receive an agreed amount of money now rather than risk getting nothing or a lesser amount later.

wYou will receive your benefits in one lump sum.

DISADVANTAGES

wA Compromise and Release usually permanently releases the employer from all future responsibilities. After your case has been resolved by a Compromise and Release Agreement, you cannot ask for more medical treatment at your employer's expense, nor can you claim additional benefits if your disability or condition becomes worse. Also, if you later die as result of the injury, your dependents would not be entitled to death benefits.

wOnce a Workers' Compensation Judge has approved your Compromise and Release, the settlement is final and it cannot be set aside except in very rare circumstances.

If you would like more information, you can receive recorded information free of charge, by calling 1-800-736-7401 or you may contact your local Information and Assistance officer (listed in the state government section of your telephone book under Department of Industrial Relations, Division of Workers' Compensation). You may also consult an attorney of your choice.

SPECIAL NOTICE TO UNREPRESENTED INJURED WORKERS

If you disagree with the rating because you believe that the rating was improperly calculated or that the doctor failed to address any or all issues or failed to properly rate your impairment, you may request administrative review of the rating within 30 days of receipt of the rating, from the Administrative Director of the Division of Workers' Compensation. In some cases, you may be entitled to an additional medical evaluation or a different medical specialist. Your request should include a copy of the rating and a copy of the report from the doctor. A copy of the request must be sent to your claims adjustor.

If you have questions about whether to request administrative review of your rating or whether another medical evaluation is appropriate, you should contact the local Information and Assistance Officer listed in the state

government section of your telephone book under Department of Industrial Relations, Division of Workers' Compensation. They can tell you how to file the request if you decide to do so.

DEU Form 110, Notice of Options Following Permanent Disability Rating (Rev 12/04) (.pdf format, 9K)

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 124, 4061, 4062, 4062.01, 4062.1, 4062.2, 4062.5, 4064, 4067, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section11351.

2. Amendment of section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

3. Amendment of section and Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 12-31-2004 order, including further amendment of section and Note, transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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New query

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§10166. Consultative Rating Determinations.

(a) The Disability Evaluation Unit will prepare consultative rating determinations upon request of the Workers' Compensation Appeals Board, Workers' Compensation Judges, Settlement Conference Referees, Arbitrators, Workers' Compensation Judges Pro-Tempore and Information & Assistance Officers.

(b) Consultative rating determinations may be requested for the purpose of determining the ratable significance of factors, reviewing proposed Compromise and Release Agreements for adequacy, determining commuted values, resolving occupational questions or any other matters within the expertise of the disability evaluators. These rating determinations are the "informal ratings" referred to in subsection (k) of section 10301 of the Workers' Compensation Appeals Board Rules of Practice and Procedure. Consultative Rating Determinations will not be admissible in judicial proceedings.

(c) The Disability Evaluation Unit may also prepare consultative rating determinations upon receipt of reasonable requests from employers, injured workers or their respective representatives. A request is not considered reasonable where an insurance carrier or self-insurer seeks a consultative rating determination for the purpose of terminating its self-insurer seeks a consultative rating determination for the purpose of terminating its liability or for negotiating a Compromise and Release settlement where the injured worker has no representative. Consultative rating determinations shall not to be used as a substitute for summary rating determinations.

(d) In all cases the person making a request for a consultative rating determination will provide the Disability Evaluation Unit with the occupation and age of the injured worker at the time of injury.

(e) No consultative rating determination will be provided on cases in which an application for adjudication of claim has been filed with the Appeals Board without prior written authorization of the Appeals Board, a Workers' Compensation Judge, Settlement Conference Referee, Arbitrator, Workers' Compensation Judge Pro-Tempore, or Information & Assistance Officer. In cases where an application has been filed, the disability evaluator may require that any request for consultative rating determination be accompanied by the Appeals Board file.

NOTE: Authority cited: Sections 133, 5307.3 and 5307.4, Labor Code. Reference: Sections 123.6, 123.7, 124, 5275, 5451, 5502, 5701 and 5703.5, Labor Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section 11351.

2. Amendment of section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to

Government Code section 11351 (Register 94, No. 4).

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New query

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§10167. Informal Ratings.

(a) An informal rating will be prepared by the Disability Evaluation Unit upon the request of the employee and/or his/her representative and the employer, or at the request of an Information and Assistance Officer providing the necessary information. Such requests shall be submitted on forms and in a manner prescribed by the administrative director. Informal ratings shall be issued only in those instances where an Application for Adjudication of Claim has not been filed with the appeals board. All medical reports pertaining to the case must be submitted with the request.

(b) The Disability Evaluation Unit will issue the informal rating, which will contain a statement that the informal rating is not: a) a finding, award, order or decision of the appeals board, and b) evidence as to the existence of the factors of disability.

(c) Where the informal rating indicates a life pension, or provision for future medical treatment appears indicated, the Disability Evaluation Unit will forward a copy of the rating to an Information and Assistance Officer for the purpose of obtaining a stipulated award, or other action as may be appropriate.

(d) Self-ratings prepared by the employer are not acceptable substitutes for informal ratings prepared by the Disability Evaluation Unit.

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Section 4061, Labor Code.

HISTORY

1. New section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No.52).

2. Amendment filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10168. Records, Destruction of. [Repealed]

Note: Authority cited: Sections 133, 135 and 5307.3, Labor Code. Reference: Sections 135 and 4061, Labor Code; and Section 14755, Government Code.

HISTORY

1. New section filed 4-25-91; operative 4-25-91 (Register 91, No. 26). New section is exempt from review by OAL pursuant to Government Code section11351.

2. Amendment filed 3-27-95; operative 3-27-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 13).

3. Amendment of section and Note filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

4. Repealer filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10169. Commutation Tables and Instructions.

Table 1 (“Present Value of Permanent Disability at 3% Interest”), Table 2 (“Present Value of Life Pension at 3% Interest for a Male”), Table 3 (“Present Value of Life Pension at 3% Interest for a Female”), and “Commutation Instructions”, as issued in January 2001, are hereby incorporated by reference in their entirety as though they were set forth below. The tables and instructions are available from any office of the Division of Workers' Compensation and may be accessed and printed from the Division's homepage at www.dir.ca.gov.

Commutation Instructions

Table 1

Table 2

Table 3

Table 1 (“Present Value of Permanent Disability at 3% Interest”) as issued in January 2001, Table 2 (“Present Value of Life Pension at 3% Interest for a Male”) as issued in July 2001, Table 3 (“Present Value of Life Pension at 3% Interest for a Female”) as issued in July 2001, and “Commutation Instructions” as issued in January 2001, are hereby incorporated by reference in their entirety as though they were set forth below. The tables and instructions are available from any office of the Division of Workers' Compensation and may be accessed and printed from the Division's homepage at www.dir.ca.gov.

NOTE

Authority cited: Sections 133, 5100, 5101, 5307.3 and 5307.4, Labor Code. Reference: Sections 5100 and 5101, Labor Code.

HISTORY

1. New section filed 1-17-2001; operative 1-17-2001 pursuant to Government Code section 11343.4(c) (Register 2001, No. 3).

2. Change without regulatory effect amending section filed 7-18-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 29).

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§10169.1. Commutation of Life Pension and Permanent Disability Benefits.

(a) Determinations of the present value of a life pension under Labor Code Section 5101(b) shall be made in accordance with the Commutation Instructions contained in Section 10169, and shall be based on the actuarial data contained in Section 10169, Table 2 (“Present Value of Life Pension at 3% Interest for a Male”) or Table 3 (“Present Value of Life Pension at 3% Interest for a Female”).

(b) Determinations of the present value of permanent disability indemnity under Labor Code Section 5101(b) shall be made in accordance with the Commutation Instructions contained in Section 10169, and shall be based on the actuarial data contained in Section 10169, Table 1 (“Present Value of Permanent Disability at 3% Interest”).

(c) The Administrative Director shall periodically revise Tables 2 and 3 of Section 10169 to incorporate revisions to the “U.S. Life Tables” and “Actuarial Tables Based On The U.S Life Tables” issued by the United States government following each decennial census.

NOTE: Authority cited: Sections 133, 5100, 5101, 5307.3 and 5307.4, Labor Code. Reference: Sections 5100, 5100.5, 5100.6 and 5101, Labor Code.

HISTORY

1. New section filed 1-17-2001; operative 1-17-2001 pursuant to Government Code section 11343.4(c) (Register 2001, No. 3).

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§10175. Definitions.

As used in this subchapter:

(a) "Employer" means any person defined as an employer in Section 3300 of the Labor Code who has secured the payment of workers' compensation benefits as required by Section 3700 of the Labor Code.

(b) "Exclusive provider of care option" means an option chosen by an employee under Section 10180 under which medical, surgical, and hospital treatment for both occupational and non occupational injuries and illness are provided to the employee through one health care service plan.

(c) "Health care service plan" means any of the following which offer a managed care product:

(1) A health care service plan licensed under Section 1353 of the Health and Safety Code (Knox-Keene Health Care Service Plan Act);

(2) A disability insurer authorized to transact health insurance or disability income insurance pursuant to Part 2 of Division 2 of the Insurance Code.

(3) An insurer authorized to transact workers' compensation insurance in California, including the State Compensation Insurance Fund.

(4) The state or an employer who has secured a certificate of consent to self-insure from the Director of Industrial Relations pursuant to Labor Code Section 3700.

(5) Multi-employer collectively bargained employee welfare benefit plans or an employee welfare benefit plan sponsored by a recognized exclusive bargaining agent for State employees.

(d) "Managed care product" means a system of medical care which provides for all of the following:

(1) All medical and health care services required under Section 4600 of the Labor Code in a manner that is timely, effective, and accessible to the employee. This shall include making available to an employee, within 5 days of a request, the services of any type of physician, as defined in Section 3209.3 of the Labor Code, including a chiropractor, following an initial visit with the employee's primary care physician, when treatment for an occupational injury or illness falls within the scope of practice of the requested type of physician.

(2) Appropriate case management, including direction of injured employees to appropriate medical service providers within a network for all non emergency services.

(3) Appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service, and mechanisms to identify and correct quality deficiencies.

(4) Adequate methods of quality assurance, peer review and service utilization review to prevent inappropriate or excessive treatment, and exclusion from participation those providers who violate treatment standards.

(5) Expertise in providing medical reports necessary for the prompt, proper administration of compensation, including those required under Sections 9785 and 10978.

(6) A procedure for resolving disputes concerning the provision of health care services under the plan, which shall be equivalent to that specified in Section 1368 of the Health and Safety Code.

(7) A program involving cooperative efforts by the employees, the employer, physicians, and other participants to promote employee wellness, workplace health and safety, and early return to work.

(8) Adequate mechanisms to assure coordinated case management goals and incentives among all providers of workers' compensation for employees with occupational injuries and diseases.

(e) "Principal place of business" means the location at which the majority of the employer's employees are employed.

(f) "Small employer" means an employer who on at least 50 percent of its working days during the calendar quarter preceding submission of the proposal under which the employer participates in the pilot project employed not more than fifty (50) employees.

(g) "Traditional health benefit plan" means a plan of medical coverage for non occupational injuries and illness provided by the employer, through a contract between the employer and a health care provider, or through a purchasing cooperative specifically authorized by state law.

(h) "Traditional workers' compensation provider" means a health care provider chosen pursuant to Labor Code Section 4600 or 4601.

NOTE: Authority cited: Sections 133, 4612, and 5307.3, Labor Code. Reference: Section 4612, Labor Code.

HISTORY

1. New subchapter 1.7 and section filed 8-31-93; operative 8-31-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 36).

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§10176. Eligible Employers and Employees.

(a) Employers whose principal place of business is in any of the following counties may participate in the pilot project:

(1) Los Angeles;

(2) San Diego;

(3) Santa Clara;

(4) Sacramento.

(b) Employees of employers eligible to participate in the pilot project who are employed in counties other than those enumerated in subdivision (a) are not precluded from participation in the project.

(c) Nothing in this section shall be construed to prohibit participation by employers whose principal place of business is not within one of the four counties listed in subdivision (a) above if the employer is specifically authorized to do so by statute.

NOTE: Authority cited: Sections 133, 4612, and 5307.3, Labor Code. Reference: Section 4612, Labor Code.

HISTORY

1. New section filed 8-31-93; operative 8-31-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 36).

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§10177. Eligible Applicants.

(a) Pilot project plan proposals may be submitted to the administrative director by any one or combination of the following entities or authorized agents thereof:

(1) Employers

(2) Heath care service plans

(3) Health insurance purchasing cooperatives specifically authorized under state law.

NOTE: Authority cited: Sections 133, 4612, and 5307.3, Labor Code. Reference: Section 4612, Labor Code.

HISTORY

1. New section filed 8-31-93; operative 8-31-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 36).

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§10178. Pilot Project Proposal Requirements.

(a) Proposals submitted to the administrative director for final approval shall include all of the following:

(1) A description of the manner in which health care services are to be provided, including the administrative and organizational structure, how each component of the managed care product will be provided, and the standards and procedures under which an employee who selects the exclusive provider of care option will be permitted to change health care service plans.

(2) The business name and tax identification number of the employer or employee, the approximate number and occupations of participating employees, the health care service plan or provider of health care services, and any other parties required in the operation of the proposal. The proposal shall include signed authorization from all necessary parties, other than the employees, confirming their commitment to the plan. In the case of a proposal under which only small employers will participate, the proposal may specify the method by which employers will be selected to participate in lieu of identifying and obtaining commitments from participating employers and identifying the approximate number and occupations of participating employees.

(3) The method whereby employees will be informed of their rights and options under the proposal, including the right to obtain a decision from the Workers' Compensation Appeals Board in the case of disputes over compensation for injuries compensable under Division 4 (commencing with Section 3200) of the Labor Code. Materials to be used for this purpose shall be submitted with the proposal. Materials shall include a description of the dispute resolution process, a description of dependent coverage, a description of the method and frequency of employee choice of health care provider and a description of any other incentives offered to employees by employers to participate in the plan.

(4) The dispute resolution process under the exclusive provider of care option, including the process made available to employees to voluntarily resolve issues subject to the jurisdiction of the appeals board, as well as the process for resolving disputes which are not subject to the jurisdiction of the appeals board.

(5) A description of how dependents will be covered under the proposal, and if co-payments, premium shares, deductibles, or other charges are to be assessed against employers or dependents for non occupational injuries and illness, the amount of such charges and how these charges will be determined and segregated in a manner to assure compliance with subdivision (a) of Section 3751 of the Labor Code.

(6) The method and frequency of employee choice as to whether the employee will receive medical care under an exclusive provider of care option.

(7) A description of any incentives offered by an employer to employees to encourage participation in the exclusive provider of care option.

(8) Verification of agreement to participate executed by an authorized representative of each exclusive or certified bargaining agent which represents employees of the employer.

(9) The method by which any workers' compensation liability of the employer incurred during the pilot project will be paid after an employee's or employer's participation in the pilot project terminates.

(10) An agreement to provide the administrative director, in the form and manner prescribed by the Administrative Director, with information necessary to evaluate the plan and compliance with this subchapter.

(11) An agreement by the participating employers, or by another participating entity on the behalf of these employers, to pay a proportionate share of the cost of the evaluation of the pilot projects approved under this subchapter, based on the number of participating employees. Nothing in this paragraph shall be construed to require participating employers to pay a share of the evaluation cost if other funding sources are authorized by statute and alternative funding is obtained for this purpose.

NOTE: Authority cited: Sections 133, 4612, and 5307.3, Labor Code. Reference: Section 4612, Labor Code.

HISTORY

1. New section filed 8-31-93; operative 8-31-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 36).

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§10179. Selection of Proposals; Priorities; Pilot Termination.

(a) Initial applications will be accepted from the date the Request for Applications is issued until March 31, 1994.

(b) The following will be given priority in selecting participants in the pilot project:

(1) Joint labor-management proposals.

(2) Proposals targeting employers who have previously not offered health benefits for non occupational injuries and illness to their employees.

(3) Proposals which include appropriate control groups to assist the evaluation process.

(4) Proposals which provide for coordinated administration of indemnity benefits, as well as medical benefits, including workers' compensation temporary disability benefits, state disability insurance benefits, and private disability benefits, while retaining separate administration of the compensation required under Division 4 (commencing with Section 3200) of the Labor Code.

(5) Proposals which will operate in more than one pilot project county.

(6) Proposals which provide parity in coverage between occupational and non occupational injuries and illness.

(7) Proposals which will commence on January 1, 1994.

(c) Proposals approved for participation in the pilot project shall commence no earlier than January 1, 1994 and shall terminate no later than December 31, 1997.

NOTE: Authority cited: Sections 133, 4612, and 5307.3, Labor Code. Reference: Section 4612, Labor Code.

HISTORY

1. New section filed 8-31-93; operative 8-31-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 36).

2. Amendment of section heading and subsection (c) filed 10-11-94; operative 10-11-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 41).

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§10180. Employee Choice Of Plans.

(a) An employee participating in a proposal approved by the administrative director must be offered a choice between the following:

(1) Receiving medical benefits under an exclusive provider of care option for both occupational and non occupational injuries and illness;

(2) Receiving medical benefits for non occupational injuries and illness from a traditional health benefit plan and receiving medical treatment for occupational injuries and illness from a traditional workers' compensation provider.

(b) Employees may be permitted to choose between the two options specified in subdivision (a) in the following ways:

(1) The employee selects an option only once, either (i) before the plan begins in the case of current employees, or (ii) at the time of employment in the case of persons employed after the initial selection period for current employees.

(2) After the initial election, the employee is permitted to change options annually, during an open enrollment period made available to all participating employees.

(c) Nothing in this section shall be construed to preclude an employee from changing plans at any time for good cause, as specified in the approved pilot project proposal or in the rules of the health care service plan.

NOTE: Authority cited: Sections 133, 4612, and 5307.3, Labor Code. Reference: Section 4612, Labor Code.

HISTORY

1. New section filed 8-31-93; operative 8-31-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 36).

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§10181. Records, Claims Administration, Auditing, and Termination.

(a) Nothing in this subchapter shall relieve any employer, health care provider or their agents from any of the requirements or obligations contained in Division 1 (commencing with Section 1) of this Title, except for the requirements of Sections 9780.1, 9781, and 9782 to the extent an approved pilot project proposal conflicts with the requirements of these sections.

(b) Administration and accounting of the payment of workers' compensation benefits under this pilot project shall be solely for the purpose of complying with the workers' compensation laws of the State of California and shall be separate from the administration of other employee welfare benefits within the meaning of 29 U.S.C. Section 1002(1). However, any benefit provided by a government plan, church plan, or benefits plan maintained solely for the purpose of compliance with unemployment compensation or disability insurance laws, within the meaning of 29 U.S.C. 1003, may be combined with the administration of workers' compensation under an exclusive provider of care option.

(c) Nothing in this subchapter or a pilot project plan shall be construed to relieve any person, including an employer or physician, from any reporting requirements concerning occupational injuries or illness, or to preclude or in any way inhibit the adjudication of issues involving occupational injuries, including whether an injury or illness is compensable under Division 4 (commencing with Section 3200) of the Labor Code, before the Workers' Compensation Appeals Board.

(d) An employer's participation in this pilot project shall terminate automatically, without any action by the administrative director, when an employer fails to secure the payment of workers' compensation in the manner prescribed by Section 3700 of the Labor Code.

NOTE: Authority cited: Sections 133, 4612, and 5307.3, Labor Code. Reference: Sections 3700, 4612, 5300, 6409 and 6409.1, Labor Code.

HISTORY

1. New section filed 8-31-93; operative 8-31-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 36).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.8. Collective Bargaining Agreements Under Labor Code Sections 3201.5 and 3201.7

New query

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§10200. Definitions.

As used in this subchapter:

(a) “Employee” means an employee covered under either:

(1) A provision of a collective bargaining agreement recognized by the Administrative Director pursuant to Labor Code section 3201.5; or

(2) A labor-management agreement recognized by the Administrative Director pursuant to Labor Code section 3201.7.

(b) “Employer” means either:

(1) For the purpose of Labor Code section 3201.5, a private employer or group of employers actually engaged in construction, construction maintenance, or activities limited to rock, sand, gravel, cement and asphalt operations, heavy-duty mechanics, surveying, and construction inspection in California. A public entity may be a member of a group of employers.

(2) For the purpose of Labor Code section 3201.7, a private employer, group of employers, or a city or county that is self-insured in compliance with Labor Code section 3700.

(c) “Labor-management agreement” under Labor Code section 3201.7 (or 3201.7 provision) means a provision, clause, addendum, or other section of a collective bargaining agreement that establishes or would establish any program permitted under Labor Code section 3201.7(a). Such a program shall be maintained solely for the purpose of complying with the requirements of Division 4 the Labor Code and shall be administered separately from any other employee benefit plan.

(d) “Provision of a collective bargaining agreement” under Labor Code section 3201.5 (or “3201.5 provision”) means a provision, clause, addendum, or other section of a collective bargaining agreement that establishes or would establish any program permitted under Labor Code section 3201.5(a). Such a program shall be maintained solely for the purpose of complying with the requirements of Division 4 the Labor Code and shall be administered separately from any other employee benefit plan.

(e) “Union” means a bona fide labor organization that is the recognized or certified exclusive bargaining representative of the employees of an employer. A labor organization is bona fide under this regulation if:

(1) it actually represents employees in California as to wages, hours and working conditions,

(2) its officers have been elected by secret ballot or otherwise in a manner consistent with federal law, and

(3) it is free of domination or interference by any employer and has received no improper assistance or support from any employer.

NOTE

Authority cited: Sections 133, 3201.5 and 5307.3, Labor Code. Reference: Sections 3201.5 and 3201.7, Labor Code.

HISTORY

1. New subchapter 1.8 and section filed 8-8-95; operative 8-8-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 32).

2. Amendment of section and Note filed 4-22-2004 as an emergency; operative 4-22-2004 (Register 2004, No. 17). A Certificate of Compliance must be transmitted to OAL by 8-20-2004 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 4-22-2004 order, including further amendment of section, transmitted to OAL 8-20-2004 and filed 10-4-2004 (Register 2004, No. 41).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.8. Collective Bargaining Agreements Under Labor Code Sections 3201.5 and 3201.7

New query

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§10201. Procedure for Determining Eligibility Under Labor Code Sections 3201.5.

(a) Every employer and union proposing to establish any program permitted by Labor Code section 3201.5 shall jointly request the Administrative Director to determine eligibility, as follows:

(1) Employers shall submit the following documents:

(A) Upon its original application and whenever it is renegotiated thereafter, a copy of the underlying collective bargaining agreement and the approximate number of employees who will be covered thereby. The collective bargaining agreement shall be complete, including side letters and all appendices and other documents referred to in the agreement that relate to the program permitted by Labor Code section 3201.5, including but not limited to trust agreements and agreements concerning providers. If the application is on behalf of a group of employers, the application shall clearly define the group and shall state whether all the members of the group are bound by the 3201.5 provision, or whether each member must individually agree to be bound.

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

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

(D) Upon its original application and annually thereafter, the name, address, and telephone number of the contact person of the employer.

(E) Upon its original application and annually thereafter, evidence that the employer is actually engaged in construction, construction maintenance, or activities limited to rock, sand, gravel, cement and asphalt operations, heavy-duty mechanics, surveying, or construction inspection in California, or has a plan for immediate engagement in one of those businesses.

(F) Upon its original application and annually thereafter, evidence that the employer:

(i) is developing or projecting an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000) or more, or has paid an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000) in at least one of the previous three years; or

(ii) is a group of employers engaged in a workers' compensation safety group complying with Sections 11656.6 and 11656.7 of the Insurance Code, and established pursuant to a joint labor management safety committee or committees,

which develops or projects annual workers' compensation insurance premiums of two million dollars ($2,000,000) or more; or

(iii) is an employer or group of employers that is self-insured in compliance with Section 3700 that has projected annual workers' compensation costs that meet the requirements of, and that meet the other requirements of, paragraph (i) in the case of employers, or paragraph (ii) in the case of groups of employers; or

(iv) is an employer, who is properly signatory to a project agreement, and is covered by an owner or general contractor provided wrap-up insurance policy applicable to a single construction site that develops workers' compensation insurance premiums of two million dollars ($2,000,000) or more with respect to those employees covered by that wrap-up insurance policy.

Every member of a group of employers must maintain separately administered workers' compensation insurance or a self-insurance program distinct from all other types of insurance. Every member must maintain this insurance or self-insurance in one of the ways enumerated in Labor Code section 3700; but it is not necessary that all members maintain insurance or a self-insurance program in the same way. Every member must meet one of the minimum premium or cost requirements listed in paragraphs (i) through (iv) above.

(G) Upon its original application and annually thereafter a statement that it is able and willing to supply the data required by Labor Code section 3201.5(i).

(H) If the application is on behalf of a group of employers, evidence that:

(i) membership in the group is limited to employers that meet all the criteria of Labor Code section 3201.5 and these regulations;

(ii) the group shall, on behalf of its individual members, provide the data required by Labor Code section 3201.5(i);

(iii) the group shall maintain records of its membership satisfactory to the Administrative Director for the purpose of readily ascertaining the facts required by Section 10201(e)(3). Membership records shall include evidence of security for the payment of compensation for each member, including the insurance policy number, or a copy of the certificate of self-insurance issued pursuant to Labor Code section 3700. Membership records shall also include the approximate number of employees for each individual member of the group who is bound by the collective bargaining agreement. Copies of membership records shall be delivered to the Administrative Director on request.

(2) Unions shall submit the following documents:

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

(B) Upon its original application and annually thereafter, the name, address, and telephone number of the contact person or persons of the collective bargaining representative or representatives.

(C) Upon its original application and annually thereafter evidence that the union is a bona fide labor organization in that:

(i) it actually represents employees engaged in construction, construction maintenance, or activities limited to rock, sand, gravel, cement and asphalt operations, heavy-duty mechanics, surveying, and construction inspection in California as to wages, hours and working conditions,

(ii) its officers have been elected by secret ballot or otherwise in a manner consistent with federal law, and

(iii) it is free of domination or interference of any employer and has received no improper assistance or support from any employer.

It will be presumed that a union is bona fide if for a period of five years it has actually entered into collective bargaining agreements with employers in California and has filed all appropriate reports with the United States Department of Labor in that period. If a union is not presumed to be bona fide, it shall present evidence satisfactory to the Administrative Director that it meets the criteria of a bona fide labor organization.

(3) Any person may submit documents to the Administrative Director that bear on the eligibility of an applicant. Copies of all such documents received shall be sent to the applicants for comment.

(b) [Reserved for regulation relating to confidentiality]

(c) Issuance of a Letter of Eligibility

Within 30 days after receiving an application, the Administrative Director shall notify the applicants that the application is complete or shall specify what further information is needed to complete the application. Within 30 days after the time an application is completed, the Administrative Director shall either (1) issue a letter of eligibility, or (2) deny eligibility. If eligibility is denied, the Administrative Director shall inform the parties of the reasons therefor. For good cause and upon written notice to the applicants, the Administrative Director may extend the periods of notification for an additional 30 days.

(d) Period of Eligibility

The letter of eligibility shall state the beginning date of eligibility, which shall be no earlier than 15 days before the parties submitted their request to the Administrative Director under this section. A letter of eligibility shall remain valid for the same period as the 3201.5 provision of the collective bargaining agreement, but no longer then three years from the date of issuance of the letter. Upon the effective date of this regulation, the Administrative Director shall re-issue letters of eligibility to parties which have already received them.

(e) Effect of a Letter of Eligibility

(1) A letter of eligibility is a determination by the Administrative Director that the parties meet the eligibility requirements of Labor Code section 3201.5. A letter of eligibility is not a determination by the Administrative Director that the collective bargaining agreement or any part of it is in compliance with Labor Code section 3201.5.

(2) A 3201.5 provision is valid and binding only if there was a letter of eligibility in effect at the time of injury.

(3) A letter of eligibility issued to a group of employers shall be valid as to an individual member of the group if all the following facts are established as of the time the provision is alleged to be in effect and at the time of injury:

(A) the group of employers possessed a current letter of eligibility;

(B) the individual employer was a member of the group;

(C) the individual employer had signed the 3201.5 provision;

(D) the individual employer was actually engaged in construction, construction maintenance, or activities limited to rock, sand, gravel, cement and asphalt operations, heavy-duty mechanics, surveying, or construction inspection in California and possesses a valid and active license as required by Labor Code section 3201.5(a); and

(E) the individual employer was is compliance with Labor Code section 3201.5(c).

(f) Renewal of Eligibility

(1) At least 30 days prior to the expiration of the letter of eligibility, the parties shall submit to the Administrative Director updated copies of the documents and other evidence required by subdivision (a) of this Section. However, if certain documents and other evidence are completely unchanged since the submission of the previous annual report

required by Section 10204, the party responsible for submitting the updates may instead submit a statement under penalty of perjury that there has been no change in the document or evidence since the previous annual report. The Administrative Director may nonetheless require any party to submit the actual documents or evidence.

(2) Within 30 days after receiving the information required under subdivision (f)(1), the Administrative Director shall either: (1) renew the letter of eligibility for the same period of time set forth in subdivision (d); or (2) deny eligibility. If eligibility is denied, the Administrative Director shall inform the parties of the reasons therefor.

(g) All insurers, self-insured employers, and third party administrators who adjust claims subject to a Section 3201.5 provision shall comply with the applicable provisions of Section 138.4 of the Labor Code and shall comply with the administrative regulations contained in Title 8, Cal. Code Regs., Division 1, Chapter 4.5:

(1) Subchapter 1: Article 1.1, commencing with Section 9700; Article 5, commencing with Section 9780; Article 6, commencing with Section 9796; Article 8, commencing with Section 9810; Article 8.5, commencing with Section 9880; Article 10, commencing with Section 9900;

(2) Subchapter 1.5: Article 1, commencing with Section 10100; Article 2, commencing with Section 10101; Article 3, commencing with Section 10105; Article 4, commencing with Section 10110; Article 5, commencing with Section 10111; Article 6, commencing with Section 10113; Article 7, commencing with Section 10115; Article 6, commencing with Section 10116; Article 7, commencing with Section 10122; and,

(3) Subchapter 1.6, commencing with Section 10150.

NOTE

Authority cited: Sections 133, 3201.5 and 5307.3, Labor Code. Reference: Section 3201.5, Labor Code.

HISTORY

1. New section filed 8-8-95; operative 8-8-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 32).

2. Amendment filed 4-22-2004 as an emergency; operative 4-22-2004 (Register 2004, No. 17). A Certificate of Compliance must be transmitted to OAL by 8-20-2004 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 4-22-2004 order, including further amendment of section, transmitted to OAL 8-20-2004 and filed 10-4-2004 (Register 2004, No. 41).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.8. Collective Bargaining Agreements Under Labor Code Sections 3201.5 and 3201.7

New query

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§10202. Procedure for Recognizing Labor-Management Agreements Under Labor Code Section 3201.7.

(a) Any union in an industry not covered by Labor Code section 3201.5 who seeks to negotiate a 3201.7 provision with an employer shall file a petition with the Administrative Director, verified under penalty of perjury, on the "Petition for Permission to Negotiate a Section 3201.7 Labor-Management Agreement" form (DWC Form RGS-1), contained in Section 10202.1. A proof of service by mail declaration shall be attached to the petition indicating that the complete petition, including all attachments, was served on the employer, or group of employers.

(b) Within 10 days after receiving a petition, the Administrative Director shall notify the union that the petition is complete or shall specify what further information is needed to complete the petition. Within 30 days after the time the petition is completed, the Administrative Director shall either (1) issue to the union and employer, or group of employers, a letter of eligibility to negotiate a 3201.7 provision, or (2) deny the petition. If the petition is denied, the Administrative Director shall inform the union of the reasons therefor. For good cause and upon written notice to the union, the Administrative Director may extend the periods of notification for an additional 30 days.

(c) The letter of eligibility to negotiate shall remain valid for a period not to exceed one year from the date of issuance. Upon joint request by the union and the employer, or group of employers, an additional one year period to negotiate a 3201.7 agreement shall be granted.

(d) Upon receipt of the letter of eligibility to negotiate, the union and employer, or group of employers, may negotiate a 3201.7 provision. A negotiated and signed 3201.7 provision between a union and employer, or group of employers, will be recognized by the Department of Industrial Relations as valid and binding upon application by the parties to the Administrative Director.

(1) The employer, or group of employers, shall submit the following documents with the application:

(A) Upon its original application and whenever it is renegotiated thereafter, a copy of the 3201.7 provision, and the approximate number of employees who will be covered thereby. If the application is on behalf of a group of employers, the application shall clearly define the group and shall state whether all the members of the group are bound by the 3201.7 provision, or whether each member must individually agree to be bound.

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

(C) Upon its original application and annually thereafter, the name, address, and telephone number of the contact person of the employer, or group of employers.

(D) Upon its original application and annually thereafter, evidence of a valid and active license where that license is

required by law as a condition of doing business in the state.

(E) Upon its original application and annually thereafter, evidence that the employer:

(i) is developing or projecting an annual workers' compensation insurance premium, in California, of fifty thousand dollars ($50,000) or more, and employing at least fifty (50) employees, or has paid an annual workers' compensation insurance premium, in California, of fifty thousand dollars ($50,000), and employing at least fifty (50) employees in at least one of the previous three years; or

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

(iii) is an employer or group of employers, including cities and counties, that is self-insured in compliance with Labor Code section 3700 that has projected annual workers' compensation costs that meet the requirements of, and that meet the other requirements of, paragraph (i) in the case of employers, or paragraph (ii) in the case of groups of employers.

(F) Upon its original application and annually thereafter a statement that it is able and willing to supply the data required by Labor Code section 3201.7(h).

(G) If the application is on behalf of a group of employers, evidence that:

(i) membership in the group is limited to employers that meet all the criteria of Labor Code section 3201.7 and these regulations;

(ii) the group shall, on behalf of its individual members, provide the data required by Labor Code section 3201.7(h);

(iii) the group shall maintain records of its membership satisfactory to the Administrative Director for the purpose of readily ascertaining the facts required by subdivision (h) of the section. Membership records shall include evidence of security for the payment of compensation for each member, including the insurance policy number, or a copy of the certificate of self-insurance issued pursuant to Labor Code section 3700. Membership records shall also include the approximate number of employees for each individual member of the group who is bound by the collective bargaining agreement. Copies of membership records shall be delivered to the Administrative Director on request.

(2) Unions shall submit the following documents with the application:

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

(B) Upon its original application and annually thereafter, the name, address, and telephone number of the contact person or persons of the collective bargaining representative or representatives.

(C) Upon its original application and annually thereafter evidence that the union is a bona fide labor organization in that:

(i) its officers have been elected by secret ballot or otherwise in a manner consistent with federal law, and

(ii) it is free of domination or interference of any employer and has received no improper assistance or support from any employer.

It will be presumed that a union is bona fide if for a period of five years it has actually entered into collective bargaining agreements with employers in California and has filed all appropriate reports with the United States Department of Labor in that period. If a union is not presumed to be bona fide, it shall present evidence satisfactory to

the Administrative Director that it meets the criteria of a bona fide labor organization.

(e) Every member of a group of employers must maintain separately administered workers' compensation insurance or a self-insurance program distinct from all other types of insurance. Every member must maintain this insurance or self-insurance in one of the ways enumerated in Labor Code section 3700; but it is not necessary that all members maintain insurance or a self-insurance program in the same way. Every member must meet one of the minimum premium or cost requirements listed above in subdivision (d)(1)(E), paragraphs (i) through (iii).

(f) Any person may submit documents to the Administrative Director that bear on the application of the union and employer, or group of employers. Copies of all such documents received shall be sent to the union and employer, or group of employers, for comment.

(g) Within 30 days after receiving the application, the Administrative Director shall notify the union and employer, or group of employers, that the application is complete or shall specify what further information is needed to complete the application. Within 30 days after the time the application is completed, the Administrative Director shall either (1) issue to the union and employer, or group of employers, a letter recognizing the 3201.7 provision, or (2) deny the application. If the application is denied, the Administrative Director shall inform the union and employer, or group of employers, of the reasons therefor. For good cause and upon written notice to the union and employer, or group of employers, the Administrative Director may extend the periods of notification for an additional 30 days.

(h) The recognition of the Section 3201.7 provision is a determination by the Administrative Director that the parties meet the eligibility requirements of Labor Code section 3201.7. Recognition is not a determination by the Administrative Director that the 3201.7 agreement, or any part of it, is in compliance with Labor Code section 3201.7.

(1) A 3201.7 provision is valid and binding only if there was a complete application filed with the Administrative Director at the time of injury.

(2) A 3201.7 provision negotiated and signed by a group of employers shall be valid as to an individual member of the group if all the following facts are established as of the time the provision is alleged to be in effect and at the time of injury:

(A) the group of employers has a complete application filed with the Administrative Director;

(B) the individual employer was a member of the group;

(C) the individual employer had signed the 3201.7 provision;

(D) the individual employer was is compliance with Labor Code section 3201.7(c).

(i) All insurers, self-insured employers, and third party administrators who adjust claims subject to a Section 3201.7 provision shall comply with the applicable provisions of Section 138.4 of the Labor Code and the administrative regulations contained in Title 8, Cal. Code Regs., Division 1, Chapter 4.5:

(1) Subchapter 1: Article 1.1, commencing with Section 9700; Article 5, commencing with Section 9780; Article 6, commencing with Section 9796; Article 8, commencing with Section 9810; Article 8.5, commencing with Section 9880; Article 10, commencing with Section 9900;

(2) Subchapter 1.5: Article 1, commencing with Section 10100; Article 2, commencing with Section 10101; Article 3, commencing with Section 10105; Article 4, commencing with Section 10110; Article 5, commencing with Section 10111; Article 6, commencing with Section 10113; Article 7, commencing with Section 10115; Article 6, commencing with Section 10116; Article 7, commencing with Section 10122; and,

(3) Subchapter 1.6, commencing with Section 10150.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Section 3201.7, Labor Code.

HISTORY

1. New section filed 8-8-95; operative 8-8-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 32).

2. Amendment of section heading, repealer and new section and amendment of Note filed 4-22-2004 as an emergency; operative 4-22-2004 (Register 2004, No. 17). A Certificate of Compliance must be transmitted to OAL by 8-20-2004 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 4-22-2004 order, including further amendment of section, transmitted to OAL 8-20-2004 and filed 10-4-2004 (Register 2004, No. 41).

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New query

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§10202.1. Petition for Permission to Negotiate a Section 3201.7 Labor-Management Agreement (DWC Form RGS-1).

View Graphic

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Section 3201.7, Labor Code.

HISTORY

1. New section filed 4-22-2004 as an emergency; operative 4-22-2004 (Register 2004, No. 17). A Certificate of Compliance must be transmitted to OAL by 8-20-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 4-22-2004 order, including further amendment of section, transmitted to OAL 8-20-2004 and filed 10-4-2004 (Register 2004, No. 41).

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New query

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§10203. Reporting Data.

(a)(1) On or before March 31 of every year, every employer subject to either a 3201.5 or 3201.7 provision shall provide the information specified in subdivision (b) for the previous calendar year. For each claim with a date of injury on or after January 1, 2004, the information reported under subdivision (b)(8) through (16) in the first mandatory reporting year under subdivision (b)(8), shall also be updated annually thereafter for the following three calendar years.

(2) To provide the information required in subdivision (b), the employer shall either:

(A) Provide the information on a form prescribed by the administrative director, either DWC Form GV-1, as set forth in Section 10203.1, or DWC Form GV-2, as set forth in Section 10203.2; or

(B) Provide the administrative director with written authorization to collect the information from the appropriate claims administrator. If the administrative director is unable to obtain the information with the written authorization, the employer shall remain responsible for obtaining and submitting the information.

(3) Groups of employers shall report the information required by this section on behalf of its members. The information shall be reported as to every individual employer covered by the 3201.5 or 3201.7 provision. Groups shall also report aggregated figures for all employers in the group covered by the 3201.5 or 3201.7 provision.

(b) The report shall contain the following information:

(1) The name of the individual employer and the union.

(2) The principal business of the employer.

(3) The dates the 3201.5 or 3201.7 provision were in effect during the previous calendar year.

(4) The name of the insurer, if any, and the insurance policy number. If self-insured, the name and certificate number of the self-insured employer.

(5) The name, address and telephone number of any administrator, ombudsperson, mediator or arbitrator employed in an alternative dispute resolution system.

(6) Hours worked by covered employees, reported by trade or craft.

(7) Payroll in accordance with the rules of the Workers' Compensation Insurance Rating Bureau [WCIRB]. Payroll shall be reported by class code as set by the WCIRB.

(8) The number of claims filed in the previous calendar year pursuant to Labor Code section 5401. The claims shall be reported in the following categories:

A. The number of claims that were medical only. As to those claims, there shall also be a report on the total amount of paid costs and the total amount of incurred costs.

B. The number of claims that included a claim for indemnity. As to those claims, there shall also be a report on total amount of paid costs and total amount of incurred costs in each of the following categories: temporary disability, permanent disability, life pensions, death benefits, vocational rehabilitation, medical services, and medical-legal expenses.

(9) The number of claims filed pursuant to Labor Code section 5401 in the previous calendar year that were resolved and the number that remained unresolved on December 31 of the previous calendar year. These numbers together should equal the total number reported in subdivision (b)(8). For the purpose of this section, “resolved” means one in which ultimate liability has been determined, even though payments may be made beyond the reporting period.

(10) Of the claims that were filed and/or resolved in the previous calendar year, the number that were resolved with a denial of compensability.

(11) Of the claims that were filed and/or resolved in the previous calendar year, the number that were resolved at each of the following stages: before mediation, at or after mediation, at or after arbitration, at or after the appeals board, or at or after the court of appeals. If the 3201.5 or 3201.7 provision contains another dispute resolution procedure, whether instead of or in addition to arbitration or mediation, the report must identify the type of procedure, its stage in the overall alternate dispute resolution process, and the same respective information regarding the resolution of claims.

(12) The title and case number of every application filed with the appeals board in the previous calendar year concerning a claim alleged by any party to fall within the 3201.5 or 3201.7 provision, regardless of whether the employee had the right to file such an application.

(13) The title and court number of every civil action, including petitions for writs and injunctions in any court, state or federal, filed in the previous calendar year, that concerned a claim alleged by any party to fall within the 3201.5 or 3201.7 provision.

(14) The number of injuries and illnesses reported on the United States Department of Labor OSHA Form No. 300 for those employees covered by the 3201.5 or 3201.7 provision. The same number multiplied by 200,000 and divided by hours worked (as reported in subdivision (b)(6)).

(15) The number of employees covered by the 3201.5 or 3201.7 provision who participated in vocational rehabilitation.

(16) If the 3201.5 or 3201.7 provision established a light-duty or return to work program, the number of employees who participated in that program.

(17) For employers covered by a 3201.7 provision, an employee survey that measures worker satisfaction with the 3201.7 alternative dispute resolution procedures. The survey shall be designed and administered by agreement between the employer and the union.

(c) In addition to the data above, the employer may include in its report any explanatory material, narrative account, or comment that the employer believes is necessary to understand the data.

(d) Notwithstanding this section, all employers shall be subject to the reporting requirements of the Workers' Compensation Information System, Title 8, Cal. Code Regs., Section 9700 et seq.

(e) The data obtained by the Administrative Director pursuant to Section 10203 shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation may create derivative works based on the collective bargaining agreements and data. Those derivative works shall not be confidential, but

shall be public.

NOTE

Authority: Sections 133, 3201.5 and 5307.3, Labor Code. Reference: Sections 3201.5, 3201.7 and 3201.9, Labor Code.

HISTORY

1. New section filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

2. Amendment of subsections (a)(1), (b)3., (b)8., (b)9.-11. and (b)13.-15. filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

3. Amendment of section and Note filed 4-22-2004 as an emergency; operative 4-22-2004 (Register 2004, No. 17). A Certificate of Compliance must be transmitted to OAL by 8-20-2004 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 4-22-2004 order, including further amendment of section, transmitted to OAL 8-20-2004 and filed 10-4-2004 (Register 2004, No. 41).

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New query

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§10203.1. Aggregate Employer Annual Report (DWC Form GV-1).

DWC form GV-1

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 3201.5, 3201.7 and 3201.9, Labor Code.

HISTORY

1. New section filed 4-22-2004 as an emergency; operative 4-22-2004 (Register 2004, No. 17). A Certificate of Compliance must be transmitted to OAL by 8-20-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 4-22-2004 order, including further amendment of section, transmitted to OAL 8-20-2004 and filed 10-4-2004 (Register 2004, No. 41).

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New query

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§10203.3. Individual Employer Annual Report (DWC Form GV-2).

DWC form GV-2

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 3201.5, 3201.7 and 3201.9, Labor Code.

HISTORY

1. New section filed 4-22-2004 as an emergency; operative 4-22-2004 (Register 2004, No. 17). A Certificate of Compliance must be transmitted to OAL by 8-20-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 4-22-2004 order, including further amendment of section, transmitted to OAL 8-20-2004 and filed 10-4-2004 (Register 2004, No. 41).

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New query

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§10204. Annual Reports.

(a) On or before March 31 of every year, the parties covered by the 3201.5 or 3201.7 provision shall submit updated copies of the documents and other evidence required by Section 10201 or Section 10202. However, if certain documents and other evidence are completely unchanged since the previous submission, the party responsible for submitting the annual update may instead submit a statement under penalty of perjury that there has been no change in the document or evidence since the previous submission. The Administrative Director may nonetheless require any party to submit the actual documents or evidence.

(b) If the parties have not submitted the updated documents required by this section, or if the employer has not timely submitted the data required by Section 10203 the Administrative Director may, after notice and an opportunity to respond, either: (1) revoke a letter of eligibility issued pursuant to Labor Code section 3201.5; (2) revoke the recognition given to the labor-management agreement negotiated pursuant to Labor Code section 3201.7; or (3) take such other steps as he or she deems necessary to secure the parties' compliance with reporting requirements.

NOTE

Authority cited: Sections 133, 3201.5 and 5307.3, Labor Code. Reference: Sections 3201.5, 3201.7 and 3201.9, Labor Code.

HISTORY

1. New section filed 8-8-95; operative 8-8-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 32).

2. Amendment of subsection (a) filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

3. Amendment of section and Note filed 4-22-2004 as an emergency; operative 4-22-2004 (Register 2004, No. 17). A Certificate of Compliance must be transmitted to OAL by 8-20-2004 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 4-22-2004 order transmitted to OAL 8-20-2004 and filed 10-4-2004 (Register 2004, No. 41).

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ARTICLE 2. THE ELECTRONIC ADJUDICATION MANAGEMENT SYSTEM

New query

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§10225. Extended System Unavailability.

(a) If, for any reason, there is a technical failure of EAMS for longer than 24 hours, the court administrator, in his or her discretion, may declare that EAMS is unavailable for an extended period of time.

(b) After issuing a declaration of extended system unavailability, the court administrator shall issue an order that includes, but is not limited to:

(1) requiring that the district office or the appeals board shall serve all documents by first class mail;

(2) providing that filed documents shall be maintained in temporary paper adjudication files;

(3) providing that the time for performing any action, whether by the parties or by the district office, shall be extended by a specified period or until EAMS is declared to be operational; or

(4) requiring or allowing any other actions or remedies, as deemed appropriate under the circumstances.

(c) The court administrator shall post the declaration of extended system unavailability on the website of the Division of Workers' Compensation, if the website remains operational, and shall post it at every district office and at the office of the appeals board.

(d) Any declaration of extended unavailability shall remain in effect until the court administrator issues a subsequent declaration that EAMS is operational.

(e) The Division of Workers' Compensation will maintain a list of any and all technical failures of EAMS that last longer than 24 hours on its website.

(f) EAMS shall be backed up daily pursuant to the State of California's information technology standards.

Note: Authority cited: Sections 127.5, 133, 5307(c) and 5500.3, Labor Code. Reference: Sections 5502 and 5700, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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ARTICLE 1. ADMINISTRATIVE PENALTIES PURSUANT TO LABOR CODE SECTION 5814.6

New query

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§ 10225.1. Schedule of Administrative Penalties Pursuant to Labor Code §5814.6. [Renumbered]

Note: Authority cited: Sections 133, 5307.3 and 5814.6, Labor Code. Reference: Sections 129.5, 139.48, 5814 and 5814.6, Labor Code; and Sections 11180-11191, Government Code.

HISTORY

1. New section filed 4-26-2007; operative 5-26-2007 (Register 2007, No. 17).

2. Change without regulatory effect former section 10225.1 to section 10112.2 filed 4-7-2008 pursuant to section 100, title 1, California Code ofRegulations (Register 2008, No. 15).

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New query

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§ 10225.2. Notice of Administrative Penalty Assessment, Appeal Hearing Procedures and Review. [Renumbered]

Note: Authority cited: Sections 133, 5307.3 and 5814.6, Labor Code. Reference: Sections 129.5, 139.48, 5300, 5814, 5814.6 and 5900 et seq., Labor Code.

HISTORY

1. New section filed 4-26-2007; operative 5-26-2007 (Register 2007, No. 17).

2. Change without regulatory effect former section 10225.2 to section 10112.3 filed 4-7-2008 pursuant to section 100, title 1, California Code ofRegulations (Register 2008, No. 15).

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Article 1.1. Workers' Compensation Information Systems

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§9700. Authority.

This article is adopted to implement the Workers' Compensation Information System mandated by Sections 138.6 and 138.7 of the Labor Code.

Authority: Sections 133, 138.6 and 138.7, Labor Code. Reference: Section 138.6, 138.7, Labor Code.

HISTORY

1. New article 1.1 (sections 9700-9704) and section filed 10-6-99; operative 11-5-99 (Register 99, No. 41).

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Chapter 4.5. Division of Workers' Compensation
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Article 1.1. Workers' Compensation Information Systems

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§9701. Definitions.

Workers' compensation information systems Web site

(a) The following definitions apply in this article:

Bona Fide Statistical Research. The analysis of existing workers' compensation data for the purpose of developing or contributing to basic knowledge regarding the California workers' compensation system.

California EDI Implementation Guide for First and Subsequent Reports of Injury. California EDI Implementation Guide, Version 2.1, dated February 2006, contains California specific reporting requirements and information excerpted from the IAIABC EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 1, issued February 15, 2002, by the International Association of Industrial Accident Boards and Commissions. The California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 2.1, dated February 2006, is posted on the Division's Web site at http://www.dir.ca.gov/dwc/WCIS.htm, will be made available by the Division of Workers' Compensation upon request, and is incorporated by reference.

California EDI Implementation Guide for Medical Bill Payment Records. California EDI Implementation Guide for Medical Bill Payment Records, Version 1.0, dated December 2005, contains the California-specific protocols and excerpts from the IAIABC EDI Implementation Guide for Medical Bill Payment Records, explains the technical design and functionality of the WCIS system, testing options for the trading partners, instructions regarding the data elements for medical billing, and copies of the required medical billing electronic forms. The California EDI Implementation Guide for Medical Bill Payment Records, Version 1.0, dated December 2005, is posted on the Division's Web site at http://www.dir.ca.gov/dwc/WCIS.htm, will be made available by the Division of Workers' Compensation upon request, and is incorporated by reference.

Claim. An injury as defined in Division 4 of the Labor Code, occurring on or after March 1, 2000, that has resulted in the receipt of one or more of the following by a claims administrator:

(1) Employer's Report of Occupational Injury or Illness, as required by Title 8, California Code of Regulations ss 14004-14005.

(2) Doctor's First Report of Occupational Injury or Illness, as required by Title 8, California Code of Regulations ss 14006-14007.

(3) Application for Adjudication filed with the Workers' Compensation Appeals Board under Labor Code s 5500 and Title 8, California Code of Regulations s 10408.

(4) Any information indicating that the injury requires medical treatment by a physician as defined in Labor Code s

3209.3.

Claims Administrator. A self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, California Insurance Guarantee Association (CIGA), or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

Claims Administrator's Agents. Any entity contracted by the claims administrator to assist in adjusting the claim(s) including third party administrators, bill reviewers, utilization review vendors, and electronic data interchange vendors.

Closed Claim. A claim in which future payment of indemnity benefits and/or provision of medical benefits cannot be reasonably expected to be due.

Data Elements. Information identified by data number (DN) and defined in the dictionary of the IAIABC EDI Implementation Guide, Release 1. Data elements set forth in Section 9702 must be transmitted on all claims, where applicable, as indicated in Section 9702. The data elements set forth in the IAIABC EDI Implementation Guide, Release 1 that are not enumerated in Section 9702 are optional and may, but need not be, submitted on any or all claims.

Electronic Data Interchange. ("EDI"). A computer to computer exchange of data or information in a standardized format acceptable to the Administrative Director.

Health Care Organization ("HCO"). Any entity certified as a health care organization by the Administrative Director pursuant to Labor Code Sections 4600.5 and 4600.6.

IAIABC EDI Implementation Guide, Release 1. EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 1, issued February 15, 2002, by the International Association of Industrial Accident Boards and Commissions. Sections 4, 5, 6, and the Appendix of EDI Implementation Guide, Release 1, are linked to the Division's Web site at http://www.dir.ca.gov/dwc/WCIS.htm, and are hereby incorporated by reference.

IAIABC EDI Implementation Guide for Medical Bill Payment Records. IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1, approved July 4, 2002, by the International Association of Industrial Accident Boards and Commissions. Sections 1 through 3, and 5 through 11 of the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1, are linked to the Division's Web site at http://www.dir.ca.gov/dwc/WCIS.htm, and are incorporated by reference.

Indemnity Benefits. Payments conferred, including those made by settlement, for any of the following: temporary disability indemnity, permanent disability indemnity, death benefits, vocational rehabilitation maintenance allowance, and employer-paid salary in lieu of compensation.

Individually Identifiable Information. Any data concerning an injury or claim that is linked to a uniquely identifiable employee, employer, claims administrator, or any other person or entity.

International Association of Industrial Accident Boards and Commissions ("IAIABC"). A professional association of workers' compensation specialists, located at 5610 Medical Circle, Suite 14, Madison, Wisconsin 53711, which is, in addition to other activities, engaged in the production and publication of EDI standards for filing workers' compensation information. Note: IAIABC asserts ownership of such EDI standards which are published in various ways and include Implementation Guides with instructions on their use, technical and business specifications and coding information to permit the transfer of data between regulatory bodies and regulated entities in a uniform and consistent manner.

WCIS. The Workers' Compensation Information System established pursuant to sections 138.6 and 138.7 of the Labor Code.

Note: Authority cited: Sections 133, 138.6 and 138.7, Labor Code. Reference: Sections 138.6 and 138.7, Labor Code.

HISTORY

1. New section filed 10-6-99; operative 11-5-99 (Register 99, No. 41).

2. Amendment filed 3-22-2006; operative 4-21-2006 (Register 2006, No. 12).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 1.1. Workers' Compensation Information Systems

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§9702. Electronic Data Reporting.

Workers' compensation information systems Web site

(a) Each claims administrator shall transmit data elements, by electronic data interchange in the manner set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records, to the WCIS by the dates specified in this section. Each claims administrator shall, at a minimum, provide complete, valid, accurate data for the data elements set forth in this section. The data elements required in subdivisions (b), (c), (d) and (e) are taken from California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records. Claims administrators shall only transmit the data elements that are set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records. Each transmission of data elements shall include appropriate header and trailer records as set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records.

(1) The Administrative Director, upon written request, may grant a claims administrator either a partial or total variance in reporting all or part of the data elements required pursuant to subdivision (e) of this section. Any variance granted by the Administrative Director under this subdivision shall be set forth in writing.

(A) A partial variance requested on the basis that the claims administrator is unable to transmit some of the required data elements to the WCIS shall be granted for a six month period only if all of the following are shown:

1. a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;

2. a documented showing that any medical data elements currently being transmitted by the claims administrator or the claims administrator's agent to public or private research or statistical entities shall be reported by the claims administrator to the WCIS; and

3. submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the request.

(B) A partial variance requested on the basis that the claims administrator is unable to report some of the required data elements to the WCIS because the data elements are not available to the claims administrator or the claims administrator's agent shall be granted for a six month period only if all of the following are shown:

1. a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;

2. a documented showing that any medical data elements currently being transmitted by the claims administrator or the claims administrator's agent to public or private research or statistical entities shall be reported by the claims administrator to the WCIS;

3. a documented showing that the claims administrator will submit to the WCIS the medical data elements available to the claims administrator or the claims administrator's agents; and

4. submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the request.

(C) A total variance shall be granted for a twelve month period if all of the following are shown:

1. a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;

2. a documented showing that the claims administrator has not contracted with a bill review company to review medical bills submitted by providers in its workers' compensation claims;

3. a documented showing that the claims administrator is unable to transmit medical data to public or private research or statistical entities; and

4. submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within twelve months from the request.

(2) "Undue hardship" shall be determined based upon a review of the documentation submitted by the claims administrator. The documentation shall include: the claims administrator's total required expenses; the reporting cost per claim if transmitted in house; and the total cost per claim if reported by a vendor. The costs and expenses shall be itemized to reflect costs and expenses related to reporting the data elements listed in subdivision (e) only.

(3) The variance period for reporting data elements under subdivisions (a)(1)(A) and (B) shall not be extended. The variance period for reporting data elements under subdivision (a)(1)(C) may be extended for additional twelve month periods if the claims administrator resubmits a written request for a variance. A claims administrator granted a variance shall submit to the WCIS all data elements that were required to be submitted under subdivision (e) during the variance period except for data elements that were not known to the claims administrator, the claims administrator's agents, or not captured on the claims administrator's electronic data systems. The data shall be submitted in an electronic format acceptable to the Division.

(b) Each claims administrator shall submit to the WCIS on each claim, within five (5) business days of knowledge of the claim, each of the following data elements known to the claims administrator:

Data Element Name DN
ACCIDENT DESCRIPTION /CAUSE 38
CAUSE OF INJURY CODE 37
CLAIM ADMINISTRATOR ADDRESS LINE 2 11
CLAIM ADMINISTRATOR ADDRESS LINE 1 10
CLAIM ADMINISTRATOR CITY 12
CLAIM ADMINISTRATOR CLAIM NUMBER 15
CLAIM ADMINISTRATOR POSTAL CODE 14
CLAIM ADMINISTRATOR STATE 13
CLASS CODE (3) 59
DATE DISABILITY BEGAN 56
DATE LAST DAY WORKED 65
DATE OF HIRE (1) 61

DATE OF INJURY 31
DATE OF RETURN TO WORK 68
DATE REPORTED TO CLAIM ADMINISTRATOR 41
DATE REPORTED TO EMPLOYER 40
EMPLOYEE ADDRESS LINE 1 (1) 46
EMPLOYEE ADDRESS LINE 2 (1) 47
EMPLOYEE CITY (1) 48
EMPLOYEE DATE OF BIRTH 52
EMPLOYEE DATE OF DEATH 57
EMPLOYEE FIRST NAME 44
EMPLOYEE LAST NAME 43
EMPLOYEE MIDDLE INITIAL (1) 45
EMPLOYEE PHONE (1) 51
EMPLOYEE POSTAL CODE (1) 50
EMPLOYEE STATE (1) 49
EMPLOYER ADDRESS LINE 1 19
EMPLOYER ADDRESS LINE 2 20
EMPLOYER CITY 21
EMPLOYER FEIN 16
EMPLOYER NAME 18
EMPLOYER POSTAL CODE 23
EMPLOYER STATE 22
EMPLOYMENT STATUS CODE (1) 58
GENDER CODE 53
INDUSTRY CODE 25
INSURER FEIN 6
INSURER NAME 7
JURISDICTION 4
MAINTENANCE TYPE CODE 2
MAINTENANCE TYPE CODE DATE 3
MARITAL STATUS CODE (2) 54
NATURE OF INJURY CODE 35
NUMBER OF DEPENDENTS (2) 55
OCCUPATION DESCRIPTION 60
PART OF BODY INJURED CODE 36
POSTAL CODE OF INJURY SITE 33
SALARY CONTINUED INDICATOR 67
SELF INSURED INDICATOR 24
SOCIAL SECURITY NUMBER (1) 42
THIRD PARTY ADMINISTRATOR FEIN 8
THIRD PARTY ADMINISTRATOR NAME 9
WAGE (1) 62
WAGE PERIOD (1) 63

(1) Required only when provided to the claims administrator.

(2) Death Cases Only.

(3) Required for insured claims only; optional for self-insured claims.

Data elements omitted under this subsection because they were not known by the claims administrator shall be submitted within sixty (60) days from the date of the first report under this subsection.

(c) Each transmission of data elements listed under (b), (d), (e), (f), or (g) of this section shall also include the

following elements for data linkage:

Data Element Name	DN
CLAIM ADMINISTRATOR CLAIM NUMBER (2) (3) (4)	15
DATE OF INJURY (2)	31
INSURER FEIN (4)	6
JURISDICTION CLAIM NUMBER (2) (3) (4)	5
MAINTENANCE TYPE CODE (1)	2
MAINTENANCE TYPE CODE DATE (1)	3
SOCIAL SECURITY NUMBER (2) (3)	42
THIRD PARTY ADMINISTRATOR FEIN (4)	8

(1) Maintenance Type Code (DN 2) and Maintenance Type Code Date (DN 3) are required for transmissions under Subsections (b), (d), (f), and (g).

(2) This number will be provided by WCIS upon receipt of the first report. The Jurisdiction Claim Number (DN 5) is required when changing a Claim Administrator Claim Number (DN 15); it is optional for other transmissions under this subsection.

(3) The Date of Injury (DN 31), Employee SSN (DN 42), and Claim Administrator Claim Number (DN 15) need not be submitted if the Jurisdiction Claim Number (DN 5) accompanies the transmission, except for transmissions required under Subsection (f).

(4) If the Jurisdiction Claim Number (DN 5) is not provided, trading partners must provide the Claim Administrator Claim Number (DN 15) and the Third Party Administrator FEIN (DN 8), or, if there is no third party administrator, the Insurer FEIN (DN 6).

(d) Each claims administrator shall submit to the WCIS within fifteen (15) business days the following data elements, whenever indemnity benefits of a particular type and amount are started, changed, suspended, restarted, stopped, delayed, or denied, or when a claim is closed or reopened, or when the claims administrator is notified of a change in employee representation. Submissions under this subsection are required only for claims with a date of injury on or after July 1, 2000, and shall not include data on routine payments made during the course of an uninterrupted period of indemnity benefits.

Data Element Name	DN
CLAIM STATUS	73
DATE DISABILITY BEGAN	56
DATE OF MAXIMUM MEDICAL IMPROVEMENT	70
DATE OF REPRESENTATION	76
DATE OF RETURN TO WORK	68
DATE OF RETURN TO WORK/RELEASE TO WORK	72
EMPLOYMENT STATUS CODE	58
LATE REASON CODE	77
PAID TO DATE/ REDUCED EARNINGS/RECOVERIES AMOUNT	96
PAID TO DATE/ REDUCED EARNINGS/RECOVERIES CODE	95
PAYMENT/ADJUSTMENT CODE	85
PAYMENT/ADJUSTMENT DAYS PAID	91
PAYMENT/ADJUSTMENT END DATE	89
PAYMENT/ADJUSTMENT PAIDTO DATE	86
PAYMENT/ADJUSTMENT START DATE	88

PAYMENT/ADJUSTMENT WEEKLY AMOUNT 87
PAYMENT/ADJUSTMENT WEEKS PAID 90
PERMANENT IMPAIRMENT BODY PART CODE (1) (2) 83
PERMANENT IMPAIRMENT PERCENTAGE (2) 84
WAGE 62
WAGE PERIOD 63

(1) May use Code 90 (Multiple Body Parts) to reflect combined rating for any/all impairments.

(2) Use actual permanent disability rating at the time of initial payment of permanent disability benefits. For compromise and release cases and stipulated settlements, use permanent disability estimate as reported to the appropriate rating organization established under Insurance Code s 11750, et seq.

(e) On and after September 22, 2006, claims administrators handling one hundred and fifty (150) or more total claims per year shall submit to the WCIS on each claim with a date of service on or after September 22, 2006, the following data elements for all medical services for which the claims administrator has received a billing or other report of provided medical services. The California EDI Implementation Guide for Medical Bill Payment Records sets forth the specific California reporting requirements. The data elements required in this subdivision are taken from California EDI Implementation Guide for Medical Bill Payment Records and the IAIABC EDI Implementation Guide for Medical Bill Payment Records. The claims administrator shall submit the data within ninety (90) calendar days of the medical bill payment. Each claims administrator shall transmit the data elements by electronic data interchange in the manner set forth in the California EDI Implementation Guide for Medical Bill Payment Records.

Data Element Name DN
ACKNOWLEDGMENT TRANSACTION SET ID 110
ADMISSION DATE 513
ADMITTING DIAGNOSIS CODE 535
APPLICATION ACKNOWLEDGMENT CODE 111
BASIS OF COST DETERMINATION CODE 564
BATCH CONTROL NUMBER 532
BILL ADJUSTMENT AMOUNT 545
BILL ADJUSTMENT GROUP CODE (5) 543
BILL ADJUSTMENT REASON CODE 544
BILL ADJUSTMENT UNITS 546
BILL SUBMISSION REASON CODE 508
BILLING FORMAT CODE 503
BILLING PROVIDER FEIN 629
BILLING PROVIDER LAST/GROUP NAME 528
BILLING PROVIDER POSTAL CODE 542
BILLING PROVIDER PRIMARY SPECIALTY CODE (4) 537
BILLING PROVIDER STATE LICENSE NUMBER (4) 630
BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER 523
BILLING TYPE CODE 502
CLAIM ADMINISTRATOR CLAIM NUMBER 15
CLAIM ADMINISTRATOR FEIN 187
CLAIM ADMINISTRATOR NAME 188
CONTRACT TYPE CODE 515
DATE INSURER PAID BILL 512
DATE INSURER RECEIVED BILL 511
DATE OF BILL 510
DATE OF INJURY 31
DATE PROCESSED 108

DATE TRANSMISSION SENT 100
DAYS/UNITS BILLED 554
DAYS/UNITS CODE 553
DIAGNOSIS POINTER 557
DISCHARGE DATE 514
DISPENSE AS WRITTEN CODE 562
DME BILLING FREQUENCY CODE 567
DRG CODE 518
DRUG NAME 563
DRUGS/SUPPLIES BILLED AMOUNT 572
DRUGS/SUPPLIES DISPENSING FEE 579
DRUGS/SUPPLIES NUMBER OF DAYS 571
DRUGS/SUPPLIES QUANTITY DISPENSED 570
ELEMENT ERROR NUMBER 116
ELEMENT NUMBER 115
EMPLOYEE FIRST NAME 44
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EMPLOYEE MIDDLE NAME/INITIAL 45
EMPLOYEE EMPLOYMENT VISA 152
EMPLOYEE GREEN CARD 153
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EMPLOYEE SOCIAL SECURITY NUMBER 42
FACILITY CODE 504
FACILITY FEIN 679
FACILITY MEDICARE NUMBER 681
FACILITY NAME 678
FACILITY POSTAL CODE 688
FACILITY STATE LICENSE NUMBER 680
HCPCS BILL PROCEDURE CODE 737
HCPCS LINE PROCEDURE BILLED CODE 714
HCPCS LINE PROCEDURE PAID CODE 726
HCPCS MODIFIER BILLED CODE 717
HCPCS MODIFIER PAID CODE 727
HCPCS PRINCIPLE PROCEDURE BILLED CODE 626
ICD-9 CM DIAGNOSIS CODE 522
ICD-9 CM PRINCIPAL PROCEDURE CODE 525
ICD-9 CM PROCEDURE CODE 736
INSURER FEIN 6
INSURER NAME 7
INTERCHANGE VERSION ID 105
JURISDICTION CLAIM NUMBER 5
JURISDICTION MODIFIER BILLED CODE (8)(10) 718
JURISDICTION MODIFIER PAID CODE (8) 730
JURISDICTION PROCEDURE BILLED CODE (8) 715
JURISDICTION PROCEDURE PAID CODE (8)(9) 729
LINE NUMBER 547
MANAGED CARE ORGANIZATION FEIN (1) 704
MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER 208
MANAGED CARE ORGANIZATION NAME 209
MANAGED CARE ORGANIZATION POSTAL CODE 712
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PRESCRIPTION BILL DATE 527
PRESCRIPTION LINE DATE 604
PRESCRIPTION LINE NUMBER 561
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RENDERING BILL PROVIDER POSTAL CODE 656
RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE 651
RENDERING BILL PROVIDER SPECIALTY LICENSE
NUMBER 649
RENDERING BILL PROVIDER STATE LICENSE NUMBER 643
RENDERING LINE PROVIDER NATIONAL ID (7) 592
RENDERING LINE PROVIDER FEIN 586
RENDERING LINE PROVIDER LAST/GROUP NAME (6) 589
RENDERING LINE PROVIDER POSTAL CODE 593
RENDERING LINE PROVIDER PRIMARY SPECIALTY
CODE (6) 595
RENDERING LINE PROVIDER STATE LICENSE NUMBER (6) 599
REPORTING PERIOD 615
REVENUE BILLED CODE 559
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SENDER ID 98
SERVICE ADJUSTMENT AMOUNT 733
SERVICE ADJUSTMENT GROUP CODE (5) 731
SERVICE ADJUSTMENT REASON CODE (5) 732
SERVICE BILL DATE(S) RANGE 509
SERVICE LINE DATE(S) RANGE 605
TEST/PRODUCTION INDICATOR 104
TIME PROCESSED 109
TIME TRANSMISSION SENT 101
TOTAL AMOUNT PAID PER BILL (2) 516
TOTAL AMOUNT PAID PER LINE (2) 574
TOTAL CHARGE PER BILL 501
TOTAL CHARGE PER LINE - PURCHASE 566
TOTAL CHARGE PER LINE - RENTAL 565
TOTAL CHARGE PER LINE 552
TRANSACTION TRACKING NUMBER 266
UNIQUE BILL ID NUMBER 500

(1) For HCO claims use the FEIN of the sponsoring organization in DN 704.

(2) Not required on non-denied bills if amount paid equals amount charged.

(3) For MPN claims use code P "Participation Agreement"

(4) Does not apply if billing provider is an organization.

(5) Required if charged and paid amounts differ.

(6) Optional if rendering provider equals billing provider.

(7) To be provided following the assignment of a National Provider Identifier by the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS").

(8) The codes for this data element are the codes that are set forth in the California Official Medical Fee Schedule, a publication of the State of California, Department of Industrial Relations (adopted pursuant to Labor Code s 5307.1 and Title 8, California Code of Regulations s 9790 et seq.).

(9) Optional if procedure billed equals procedure paid.

(10) Use when a modifier has been provided.

(f) Notwithstanding the requirement in Subsection (b) to submit data elements omitted from the first report within 60 days from the date of transmission of the first report, when a claims administrator becomes aware of an error or need to update data elements previously transmitted, or learns of information that was previously omitted, the claims administrator shall transmit the corrected, updated or omitted data to WCIS no later than the next submission of data for the affected claim.

(g) No later than January 31 of every year, commencing in 2001, claims administrators shall, for each claim with a date of injury on or after July 1, 2000 and with any payment in any benefit category in the previous calendar year, report the total paid in each payment category through the previous calendar year by submitting the following data elements:

Data Element Name	DN
PAID TO DATE/REDUCED EARNINGS/RECOVERIES AMOUNT	96
PAID TO DATE/REDUCED EARNINGS/RECOVERIES CODE	95
PAYMENT/ADJUSTMENT CODE	85
PAYMENT/ADJUSTMENT END DATE	89
PAYMENT/ADJUSTMENT PAID TO DATE	86
PAYMENT/ADJUSTMENT START DATE	88

(h) Final reports (MTC = FN) are required only for claims where indemnity benefits are paid. For medical-only claims, the final report may be reported under this section or on the annual report (MTC = AN) with claim status = "closed."

(i)(1) A claims administrator's obligation to submit copies of benefit notices to the Administrative Director pursuant to Labor Code Section 138.4 is satisfied upon written determination by the Administrative Director that the claims administrator has demonstrated the capability to submit complete, valid, and accurate data as required under Subsection (d) and continued compliance with that subsection.

(2) Reserved.

(3) On and after September 22, 2006, a claims administrator's obligation to submit an Annual Report of Inventory pursuant to Title 8, California Code of Regulations, section 10104 is satisfied upon determination by the Administrative Director that the claims administrator has demonstrated the capability to submit complete, valid, and accurate data as required under subdivisions (b), (d), (e), and (g), and continued compliance with those subsections.

(j) The data submitted pursuant to this section shall not have any application to, nor be considered in, nor be admissible into, evidence in any personal injury or wrongful death action, except as between an employee and the employee's employer. Nothing in this subdivision shall be construed to expand access to information held in the WCIS beyond that authorized in section 9703 and Labor Code section 138.7.

(k) Each claims administrator required to submit data under this section shall submit to the Administrative Director an EDI Trading Partner Profile at least thirty days prior to its first transmission of EDI data. Each claims administrator shall advise the Administrative Director of any subsequent changes and/or corrections made to the information provided in the EDI Trading Partner Profile by filing a corrected copy of the EDI Trading Partner Profile with the Administrative Director.

Note: Authority cited: Sections 133, 138.4, 138.6 and 138.7, Labor Code. Reference: Sections 138.4, 138.6 and 138.7, Labor Code.

HISTORY

1. New section filed 10-6-99; operative 11-5-99 (Register 99, No. 41).

2. Amendment filed 3-22-2006; operative 4-21-2006 (Register 2006, No. 12).

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Article 1.1. Workers' Compensation Information Systems

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§9703. Access To Individually Identifiable Information.

Workers' compensation information systems Web site

(a) No person shall have access to individually identifiable data held in the WCIS except as provided in this section and subdivision (c) of section 138.7 of the Labor Code.

(b) The Division of Workers' Compensation may obtain and use individually identifiable information for the following purposes:

(1) To create and maintain the WCIS, including the selection of claims to survey in order to obtain information not available from the data elements provided by claims administrators.

(2) To help select claims administrators for audits under section 129 of the Labor Code.

(3) To report the promptness with which claims administrators make payments.

(4) To electronically import names, addresses, and other information into Division of Workers' Compensation case files which would otherwise have to be key entered by agency staff.

(5) To conduct research related to the workers' compensation system for the purpose of carrying out the duties of the Division of Workers' Compensation or the Administrative Director.

(c) The following agencies may obtain individually identifiable information from the WCIS, in the manner set forth in a memorandum of understanding between the Administrative Director and the agency, for the purposes specified:

(1) The Division of Occupational Safety and Health may use individually identifiable information to help select employers for health and safety consultations and inspections.

(2) The Division of Labor Statistics and Research may use individually identifiable information to carry out its research and reporting responsibilities under Labor Code sections 150 and 156.

(3) The Department of Health Services may use individually identifiable information to carry out its occupational health and occupational disease prevention responsibilities under section 105175 of the Health and Safety Code.

(d) Upon written request to the Administrative Director, researchers employed by or under contract to the Commission on Health and Safety and Workers' Compensation (CHSWC) may obtain individually identifiable information from the WCIS, in the manner set forth in a memorandum of understanding between the Administrative Director, the commission, and the person or entity conducting research, for the purpose of bona fide statistical research.

(1) Any request from the CHSWC for individually identifiable information under this subdivision shall include the identity of the person or entity conducting the research, the purpose of the research, the research protocol, the need for individually identifiable WCIS data, and an anticipated completion date for the research.

(2) Researchers under contract to the CHSWC seeking individually identifiable WCIS data under this subdivision shall also submit to the Administrative Director written approval of the research protocol by an Institutional Review Board in the same manner as required under subdivision (e). If the researcher under contract to the CHSWC is the University of California or a non profit educational institution, the researcher shall comply with the provisions of Civil Code section 1789.24 subdivision (t).

(3) Individually identifiable information obtained under this subdivision shall not be disclosed to the members of the CHSWC.

(4) No individually identifiable information obtained by researchers under this subdivision may be disclosed to any other person or entity, public or private, for a use other than that research project for which the information was obtained.

(5) Researchers obtaining individually identifiable information under this subdivision shall notify the Administrative Director when the research has been completed. Except as required by researchers subject to subdivision (f), within 30 days thereafter, the CHSWC shall present evidence to the Administrative Director that the data collected has been modified in a manner so that the subjects cannot be identified, directly or through identifiers linked to the subjects.

(e) Individually identifiable information may be provided to other persons or public or private entities for the purpose of bona fide statistical research which does not divulge individually identifiable information concerning any employee, employer, claims administrator, or any other person or entity. Any request for individually identifiable information for this purpose shall include the identity of the requester, the purpose of the research, the methods of research, and the need for individually identifiable WCIS data. The requester shall also submit written approval of the research protocol by an Institutional Review Board, under Title 45, Code of Federal Regulations, Part 46, Subpart A. "Approval" means a determination by the Institutional Review Board that the research protocol was reviewed and provides sufficient safeguards to ensure the confidentiality of individually identifiable information. Any agreement to permit use of the data shall be in writing between the requester and the Administrative Director. Note: The Division shall make available upon request a list of Institutional Review Boards known to the Division that have the authority to grant the required approval and that expressed willingness to review research proposals under this section.

(f) The University of California or any non profit educational institution conducting scientific research must comply with the provisions of Civil Code section 1798.24 subdivision (t).

(g) Each agreement or memorandum of understanding entered concerning the use of individually identifiable information by any agency, entity, or person shall specify the methods to be used to protect the information from unlawful disclosure, and shall include a warning to the receiving party that it is unlawful for any person who has received individually identifiable information from the Division of Workers' Compensation under this section to provide the information to any person who is not entitled to it under this section and Labor Code s 138.7.

(h) Nothing in this section shall be construed to exempt from disclosure any public record contained in an individual's file once an Application for Adjudication has been filed with the Workers' Compensation Appeals Board. This includes any data from an individual's file that are converted to or stored in an electronic format for the purpose of case processing and tracking.

(i) Nothing in this section shall be construed to exempt from disclosure WCIS data in a format that does not contain individually identifiable information.

Note: Authority cited: Sections 127, 133, 138.4, 138.6 and 138.7, Labor Code. Reference: Sections 129, 138.4, 138.6 and 138.7, Labor Code; and Section 1798.24, Civil Code.

HISTORY

1. New section filed 10-6-99; operative 11-5-99 (Register 99, No. 41).

2. Amendment filed 3-22-2006; operative 4-21-2006 (Register 2006, No. 12).8 CA ADC s 9703

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Article 1.1. Workers' Compensation Information Systems

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§9704. WCIS Advisory Committee.

(a) The Administrative Director shall maintain a Workers' Compensation Information System Advisory Committee, which shall include, but not be limited to, representatives of claims administrators (including self-insured employers, insurers, and third party administrators), insured employers, organized labor, attorneys, physicians as defined in Labor Code § 3209.3, vocational rehabilitation counselors, academic researchers, the Department of Insurance statistical agent, and appropriate legislative committees and state agencies with jurisdiction over workers' compensation, occupational health, and related areas, including the Commission on Health and Safety and Workers' Compensation and the Employment Development Department.

(b) The advisory committee shall meet at least annually on the call of the Administrative Director, and may provide advice on all aspects of WCIS. The Administrative Director, or his or her designee, shall present to the advisory committee any plan to collect survey data, including any expanded collection of the data elements specified in subdivision (d) of section 9702.

NOTE: Authority: Sections 133, and 138.6, Labor Code. Reference: Section 138.6 and 138.7, Labor Code

HISTORY

1. New section filed 10-6-99; operative 11-5-99 (Register 99, No. 41).

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§9710. Authority.

The rules and regulations contained in Article 1.5 are adopted pursuant to the authority contained in Sections 123, 123.5(a) and 133 of the California Labor Code.

NOTE: Authority cited: Sections 123, 123.5 and 133, Labor Code. Reference: Chapters 402 and 414, Statutes of 1980.

HISTORY

1. New Article 1.5 (Sections 9710-9715) filed 1-16-81; effective thirtieth day thereafter (Register 81, No. 3).

2. Amendment of article heading, section and Note filed 1-12-99; operative 2-11-99 (Register 99, No. 3).

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§9711. Operative Date.

The provisions of this Article shall first apply to cases submitted after January 1, 1981, and the affidavit shall first be required for the April 1981 pay period. For the purposes of this Article, all cases submitted prior to January 1, 1981 shall be deemed to have been submitted on January 2, 1981.

NOTE: Authority cited: Sections 123, 123.5(a) and 133, Labor Code. Reference: Sections 123.5(a) and 5313, Labor Code.

HISTORY

1. New Note filed 1-12-99; operative 2-11-99 (Register 99, No. 3). §9712. Definitions.

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§9712. Definitions.

For the purposes of this Article and Section 123.5 of the Labor Code, the following definitions shall apply:

(a) "Salary" shall include ordinary pay, but shall not include sick leave pay, industrial disability leave or non-industrial disability insurance substantiated by a physician's report.

(b) "Cause" shall mean a cause of action arising out of the substantive rights, liabilities and duties provided for in Sections 132(a) and 139.5, and in Divisions 4 and 4.5 of the Labor Code which is pending before a Workers' Compensation Judge for decision.

(c) "Undetermined" means that the Workers' Compensation Judge's decision has not been filed in the record.

(d) "Submission," for the purposes of this Article means the closing of the record for the receipt of further evidence or argument.

NOTE: Authority cited: Sections 123, 123.5(a) and 133, Labor Code. Reference: Sections 123.5(a) and 5313, Labor Code.

HISTORY

1. Amendment of section and new Note filed 1-12-99; operative 2-11-99 (Register 99, No. 3).

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§9713. Receipt of Salary.

A Workers' Compensation Administrative Law Judge may not receive his or her salary while any cause before the Workers' Compensation Administrative Law Judge remains pending and undetermined for ninety (90) days after it has been submitted for decision.

NOTE: Authority cited: Sections 123, 123.5(a) and 133, Labor Code. Reference: Sections 123.5(a) and 5313, Labor Code.

HISTORY

1. Amendment of section and new Note filed 1-12-99; operative 2-11-99 (Register 99, No. 3).

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§9714. Procedures for Compliance with Labor Code Section 123.5.

(a) In order to receive his or her salary for each pay period, at some time before 5:00 p.m. on the last working day of each State payroll period, the Workers' Compensation Administrative Law Judge shall submit to the Division of Workers' Compensation an affidavit based upon information and belief in the form prescribed by Section 9714.5, and executed under penalty of perjury, declaring that no cause submitted before him or her remains pending and undetermined for a period of ninety (90) days or more.

(b) When a Workers' Compensation Administrative Law Judge who receives salary by automatic direct deposit does not timely submit the affidavit required by subsection (a), he or she shall, before 5:00 p.m. on the next working day following the direct deposit of salary into his or her account, deliver to the Presiding Workers' Compensation Administrative Law Judge of the district office to which the judge is assigned a money order or cashier's check for the amount of salary automatically deposited.

NOTE

Authority cited: Section 133, Labor Code. Reference: Sections 123.5(a) and 5313, Labor Code.

HISTORY

1. Amendment of section heading and section and new Note filed 1-12-99; operative 2-11-99 (Register 99, No. 3).

2. Amendment of subsection (a) and Note filed 5-23-2001; operative 6-22-2001 (Register 2001, No. 21).

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§9714.5. Affidavit.

Department of Industrial Relations
Division of Workers' Compensation
Workers' Compensation Appeals Board

AFFIDAVIT

(Labor Code Section 123.5(a))

I, _____, (Name) Workers' Compensation Administrative Law Judge in the _____ (City) office of the Division of Workers' Compensation/Workers' Compensation Appeals Board, Department of Industrial Relations, State of California, declare that I have made a reasonable and diligent inquiry concerning those matters submitted to me, and based on information and belief, state that no cause remains pending and undetermined that has been submitted to me for the period of ninety (90) days prior to the first day of _____, 20_____. (Date) (Year)

Executed on _____ at _____,

(Date) (City)

California. I declare under penalty of perjury that the foregoing is true and correct.

(Signature)

Workers' Compensation Administrative Law Judge

NOTE

Authority cited: Section 133, Labor Code. Reference: Sections 123.5(a) and 5313, Labor Code.

HISTORY

1. Amendment filed 1-12-99; operative 2-11-99 (Register 99, No. 3).

2. Amendment of section and new Note filed 5-23-2001; operative 6-22-2001 (Register 2001, No. 21).

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§9715. Procedures for Submitting a Cause for Decision.

Minutes of Hearing must be prepared at the conclusion of each hearing and filed in the record. Workers' Compensation Judges are to follow the provisions of Rules of Practice and Procedure Section 10566. Each set of minutes must include a disposition which includes the time and action, if any, required for submissions.

Thereafter, any change in or modification of the disposition must be served on all parties forthwith, together with the statement of the reasons for the change of disposition.

A hearing has not been concluded if the disposition includes an order taking off calendar or an order of continuance for further hearing with or without notice. Continuances and further hearings are governed by Rules of Practice and Procedure Sections 10548 and 10560.

NOTE: Authority cited: Sections 123, 123.5(a) and 133, Labor Code. Reference: Sections 123.5(a) and 5313, Labor Code.

HISTORY

1. Amendment of first paragraph and new Note filed 1-12-99; operative 2-11-99 (Register 99, No. 3).

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New query

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§9720.1. Authority.

The rules and regulations contained in Article 1.6 are adopted pursuant to the authority contained in Sections 123.6, 133, and 5307.3 of the Labor Code. This article is designed to enforce the highest ethical standards among workers' compensation administrative law judges and to provide all parties with an independent, impartial investigation into allegations of ethics violations by workers' compensation administrative law judges.

Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New article 1.6 and section filed 11-30-95; operative 12-1-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 48).

2. Amendment of article heading and section filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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New query

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§9720.2. Definitions.

For purposes of this Article and Section 123.6 of the Labor Code, the following definitions shall apply:
(a) "Code of Judicial Ethics" shall mean the Code of Judicial Ethics adopted by the Supreme Court pursuant to subdivision (m) of Section 18 of Article VI of the California Constitution and any subsequent revision thereof.

(b) "Committee" shall mean the Workers' Compensation Ethics Advisory Committee specified in Section 9722 of these regulations.

(c) "Complaint" shall mean a statement alleging facts that, if true, might constitute an ethics violation.

(d) "Ethics violation" shall mean any conduct of a workers' compensation administrative law judge that is contrary to the Code of Judicial Ethics or to the other rules of conduct that apply to workers' compensation administrative law judges.

(e) "Financial interest" shall mean a legal or equitable interest of either more than one per cent (1%) or a fair market value in excess of two thousand dollars ($2,000). Ownership in a mutual fund or other common investment fund that holds securities is not a "financial interest" in those securities unless the judge participates in the management of the fund.

(f) "Gift" means any payment or furnishing of value to the extent that consideration of equal or greater value is not given and includes a rebate or discount in the price of anything of value unless the rebate or discount is made in the regular course of business to members of the public without regard to official status. Any person who claims that a payment is not a gift by reason of the giving of consideration has the burden of proving that the consideration received is of equal or greater value. The term "gift" does not include:

(1) Informational material such as books, reports, pamphlets, calendars, periodicals, cassettes and discs, or free or reduced-price admission, tuition, or registration, for informational conferences or seminars. No payment for travel or reimbursement for any expenses shall be deemed "informational material."

(2) Gifts which are not used and which, within 30 days after receipt, are returned to the donor or delivered to a charitable organization without being claimed as a charitable contribution for tax purposes.

(3) Gifts from a judge's spouse, fiancee, child, parent, grandparent, grandchild, brother, sister, parent-in-law, brother-in-law, sister-in-law, nephew, niece, aunt, uncle, or first cousin or the spouse of any such person; provided

that a gift from any such person shall be considered a gift if the donor is acting as an agent or intermediary for any person not covered by this paragraph.

(4) Campaign contributions required to be reported under Chapter 4 (commencing with Section 84100) of Title 9 of the Government Code.

(5) Gifts of comestible items of nominal value that are not directed to a particular judge, such as holiday baskets of candy or fruit delivered to a District office of the Division, and placed in public areas for consumption by members of the public.

(6) Any devise, inheritance, or other transfer to the judge occurring as a result of death or distribution from an irrevocable trust.

(7) Personalized plaques and trophies with an individual value of less than the amount specified from time to time in Government Code § 82028 (which at the time of this amendment is two hundred fifty dollars ($ 250).

(8) Admission to events and refreshments and similar non-cash nominal benefits provided to a judge during the entire event at which the judge gives a speech, participates in a panel or seminar, or provides a similar service, and payments, advances, or reimbursements for actual transportation and any reasonably necessary lodging and subsistence provided directly in connection with the speech, panel, seminar, or service, provided that the lodging and subsistence expenses are limited to the day immediately preceding, the day of, and the day immediately following the speech, panel participation or seminar, and the travel is within the United States.

(9) Complimentary admission to events and refreshments and similar non-cash nominal benefits, at legal educational events at which the judge is not a speaker or participant in a panel, if:

A. the educational event is open to the public who wish to purchase admission;

B. continuing legal education credits are available for attorneys who attend; and

C. the free admission is offered to all workers' compensation administrative law judges;

"Complimentary admission to events"does not include admission to non-educational functions, such as golf tournaments, excursions, picnics, and dances. "Refreshments" does not include meals other than meals served contemporaneously with an educational presentation, and is limited to those refreshments offered to all who pay admission to the event.

(g) "Honorarium" shall mean any payment made in consideration for any speech given, article published, or attendance at any public or private conference, convention, meeting, social event, meal, or like gathering.

(1) "Honorarium" does not include earned income for personal services which are customarily provided in connection with the practice of a bona fide business, trade, or profession, such as teaching or writing for a publisher.

(2) For purposes of this article, "teaching" includes presentations to impart educational information to students in bona fide educational institutions, to associations or groups of judges, and to presentations of the State Bar of California or a section of the State Bar of California. An individual is presumed to be engaged in the bona fide profession of teaching in any of the following circumstances:

(A) The individual receives payment for teaching students at a bona fide educational institution.

(B) The individual receives payment for teaching students enrolled in an examination preparation program, such as a bar examination review course.

(C) The individual receives payment for teaching or making a presentation or participating in a panel presentation at an educational program offered by an association or group of judges, or at an educational program of the State Bar of California or of a section of the State Bar of California.

(h) "Judge" shall mean a worker's compensation administrative law judge and presiding workers' compensation administrative law judge employed by the Administrative Director and supervised by the Court Administrator pursuant to Section 123.5 of the Labor Code. The term shall also include Vocational Rehabilitation Consultants, Regional Managers (Associate Chief Judges) the Chief Judge, the Court Administrator, the Administrative Director, pro tem administrative law judges, and the Administrative Director's designees, but only while they are exercising judicial or quasi-judicial powers. The term does not include Information and Assistance Officers, Workers' Compensation Compliance Officers (Auditors), nor Disability Evaluation Specialists.

(i) "Previously earned compensation" shall mean legal fees and other compensation to which a workers' compensation administrative law judge may be entitled arising out of the practice of law, engaged in before the judge was appointed to be a judge. Previously earned compensation includes compensation to which the judge was contingently entitled as of the time of appointment, but which became fixed in amount after appointment.

(j) "Spouse" shall include "domestic partner".

(k) "Third degree of relationship" shall mean the following persons: great-grandparent, grandparent, parent, uncle, aunt, brother, sister, child, grandchild, great-grandchild, nephew, and niece.

Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New section filed 11-30-95; operative 12-1-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 48).

2. Amendment filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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New query

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§9721.1. Code of Judicial Conduct or Ethics.

Every workers' compensation administrative law judge shall abide by the Code of Judicial Ethics.

Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New section filed 11-30-95; operative 12-1-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 48).

2. Amendment of section heading and section filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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New query

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§9721.2. Gifts, Honoraria and Travel.

(a) No workers' compensation administrative law judge shall accept any gift or favor, the acceptance of which is prohibited by the Code of Judicial Ethics, or the transmission of which is prohibited by the Rules of Professional Conduct of the State Bar of California.

(b) No workers' compensation administrative law judge shall accept gifts from any single source in any calendar year with a total value of more than the greater of three hundred ninety dollars ($390) and the amount specified for that year in regulations of the Fair Political Practices Commission interpreting Government Code § 89503 (currently Title 2, Regulation §18940.2). This section shall not be construed to authorize the receipt of gifts that would otherwise be prohibited by the Code of Judicial Ethics, Government Code section 19990, the Political Reform Act of 1974 and any amendment thereto, the Rules of Professional Conduct of the State Bar of California, or any other provision of law.

(c) The limitation of subdivision (b) shall not apply to or limit the following:

(1) Payments, advances, or reimbursements for travel and related lodging and subsistence described in subdivision (d).

(2) Wedding gifts and gifts exchanged between individuals on birthdays, holidays and other similar occasions, provided that the gifts exchanged are not substantially disproportionate in value.

(3) A gift from any person whose pre-existing relationship with a judge would disqualify the judge under the Code of Judicial Ethics from hearing a case involving that person.

(d) Payments, advances, or reimbursements, for travel, including actual transportation and related lodging and subsistence which is reasonably related to a judicial or governmental purpose, or to an issue of state, national, or international public policy, are excluded from the limits prescribed by subdivision (b) if any of the following apply:

(1) The travel is provided by a government, a governmental agency or authority, a foreign government, a bona fide public or private educational institution, as defined in Section 203 of the Revenue and Taxation Code, a nonprofit organization which is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, or by a person domiciled outside the United States who substantially satisfies the requirements for tax exempt status under Section 501(c)(3) of the Internal Revenue Code.

(2) The travel is provided by the California State Bar or a section of the California State Bar, a state bar association, or professional association of judges in connection with testimony before a governmental body or attendance at any professional function hosted by the bar, bar association or professional association of judges, and the lodging and subsistence expenses are limited to the day immediately preceding, the day of, and the day immediately following the professional function.

(e) Payments, advances, and reimbursements for travel not described in either subdivision (c) of this Section or subdivision (f)(8) of Section 9720.2 are subject to the limit in subdivision (b).

(f) No workers' compensation administrative law judge shall accept any honorarium unless allowed in writing by the Court Administrator, if either:

(1) the cost of the honorarium is significantly paid for by attorneys who practice before the Workers' Compensation Appeals Board; or

(2) the judge would be required to report the receipt of income or gifts from the source of payment for the honorarium on the judge's statement of economic interests

(g) This section does not apply to any honorarium that is not used and within 30 days after receipt, is either returned to the donor or delivered to the Controller for deposit in the General Fund without being claimed as a deduction from income for tax purposes.
(h) The Court Administrator shall enforce the prohibitions of this section.

(i) Judges may not accept honoraria or travel allowed by the Court Administrator, and not otherwise prohibited by this section in connection with any public or private conference, convention, meeting, social event, or like gathering, the cost of which is significantly paid for by attorneys who practice before the board, unless the Court Administrator, or his or her designee, has provided prior approval in writing to the workers' compensation administrative law judge allowing him or her to accept the payments. This section shall not be construed to authorize the acceptance of an honorarium, as defined by Government Code section 89501, the acceptance of which is prohibited by Government Code section 89502.

(j) Honoraria to give a speech, participate in a panel or seminar, or provide a similar service, are allowed within the meaning of Labor Code section 123.6 where the event is sponsored by one of the following:

A professional association of judges, the State Bar of California, a section of the State Bar of California, a government, a governmental agency or authority, a foreign government, a state, national or local bar association not comprised primarily of either defense or applicant workers' compensation attorneys, a foreign bar association, an international service organization, a bona fide public or private educational institution as defined in Section 203 of the Revenue and Taxation Code, a nonprofit organization which is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, or by a person domiciled outside the United States who substantially satisfies the requirements for tax exempt status under Section 501(c)(3) of the Internal Revenue Code.

(k) Upon request to the Court Administrator by a judge, the Court Administrator may approve honoraria and travel reimbursement to give a speech, participate in a panel or seminar, or provide a similar service, where the event is sponsored by a person or entity not listed in subdivision (j) of this section.

(l) Payment, provision, or reimbursement for travel in connection with a judge's speech, participation in a panel or seminar, or provision of a similar service, if the event is sponsored by a professional association of judges, the State Bar of California, or a section of the State Bar of California, a government, a governmental agency or authority, a

foreign government, a foreign bar association, a bona fide public or private educational institution as defined in Section 203 of the Revenue and Taxation Code, a nonprofit organization which is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, or by a person domiciled outside the United States who substantially satisfies the requirements for tax exempt status under Section 501(c)(3) of the Internal Revenue Code, is allowed within the meaning of Labor Code section 123.6 for actual transportation and any reasonably necessary lodging and subsistence provided directly in connection with the speech, panel, seminar, or service, provided that the lodging and subsistence expenses are limited to the day immediately preceding, the day of, and the day immediately following the speech, panel participation or seminar, and the travel is within the United States.

(m) Payment, provision, or reimbursement for a judge's travel, including actual transportation and related lodging and subsistence, that is reasonably related to a legislative or governmental purpose, or to an issue of state, national, or international public policy, that is provided by a government, a governmental agency or authority, a foreign government, a bona fide public or private educational institution as defined in Section 203 of the Revenue and Taxation Code, a nonprofit organization which is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, or by a person domiciled outside the United States who substantially satisfies the requirements for tax exempt status under Section 501(c)(3) of the Internal Revenue Code, is allowed within the meaning of Labor Code section 123.6, and may also be accepted when prior approval of the Court Administrator is not required.

(n) Upon approval by the Court Administrator, payment, provision, or reimbursement for a judge's travel in connection with a speech, participation in a panel or seminar, or provision of a similar service, if the event is sponsored by, or if the payment or reimbursement is to be made by, an association or group of attorneys who practice before the appeals board, will be allowed for the following:

Refreshments and similar non-cash nominal benefits provided to a judge during the entire event at which the judge gives a speech, participates in a panel or seminar, or provides a similar service, actual transportation and any reasonably necessary lodging and subsistence provided directly in connection with the speech, panel, seminar, or service. Reasonably necessary subsistence is limited to meals and beverages served contemporaneously with a breakfast, dinner, or luncheon speech, panel participation or seminar, and to meals consumed while traveling to or from the activity, limited to the days of necessary travel.

(o) When prior approval of the Court Administrator is not required, payment or reimbursement for travel in connection with a speech, participation in a panel or seminar, or provision of a similar service, if the event is sponsored by a professional association of judges, the State Bar of California, or a section of the State Bar of California, a government, a governmental agency or authority, a foreign government, a foreign bar association, an international service organization, a bona fide public or private educational institution as defined in Section 203 of the Revenue and Taxation Code, a nonprofit organization which is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, or by a person domiciled outside the United States who substantially satisfies the requirements for tax exempt status under Section 501(c)(3) of the Internal Revenue Code, may be accepted for actual transportation and any reasonably necessary lodging and subsistence provided directly in connection with the speech, panel, seminar, or service, provided that the lodging and subsistence expenses are limited to the day immediately preceding, the day of, and the day immediately following the speech, panel participation or seminar, and the travel is within the United States.

Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New section filed 11-30-95; operative 12-1-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 48).

2. Amendment filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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§9721.11. Requirement for Disclosure.

A judge shall disclose to all parties or attorneys in a case, at the time the judge first becomes aware of the existence of the facts, any and all of the following:

(a) That the judge served as a lawyer for a party at any time within the three years before being assigned to the case. "Serving as a lawyer" includes having interviewed a prospective client and learned confidential information, although the judge did not become a lawyer for the prospective client. A judge shall use the resources reasonably available to the judge to ascertain the identity of the judge's former clients.

(b) That the judge provided legal advice on the specific issue presently at bar to a party involved in the instant action or proceeding.

(c) That within the past two years, a party, officer, director, or trustee of a party was a client of the judge or of a lawyer with whom the judge was associated in private practice, as an employee or on a contract basis.

(d) That a lawyer, associate of the lawyer in private practice, or spouse of a lawyer in the proceeding is a spouse, former spouse, child, sibling, or parent of the judge or of the judge's spouse.

(e) That the judge has, as a lawyer or public official, participated in the drafting of enacted laws or actively participated in the effort to pass or defeat laws, the meaning, effect, or application of which is in issue in the proceeding. "Actively participated" means the judge has engaged in lobbying, or made other substantial efforts to change law. Mere membership in an organization which advocates or has advocated change in law does not constitute active participation.

(f) Any information that the workers' compensation administrative law judge believes would be relevant to the issue of disqualification, such that a person aware of the facts might reasonably entertain a doubt as to the workers' compensation administrative law judge's ability to be impartial.

(g) Any situation known to the judge, disclosure of which is required by the Code of Judicial Ethics.

(h) That the judge has a disputed workers' compensation claim against a party.

Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New section filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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§9721.12. Disqualification.

(a) A judge is disqualified in a workers' compensation case if any of the following is true:

(1) The judge has personal knowledge of disputed evidentiary facts.

(2) The judge served as lawyer for a party in the past two years.

(3) The judge has actual bias in favor of or against any party and the judge has substantial doubt as to his or her capacity to be impartial.

(4) Because of physical impairment, the judge is unable to perceive evidence or properly conduct proceedings.

(5) Within the past two years, the judge served as a lawyer for an officer, director, trustee of a party.

(6) Within the past two years, the judge was associated in private practice, as an employee or on a contract basis, with a lawyer in the proceedings.

(7) The judge, the judge's spouse, or minor child of the judge, personally or as a fiduciary, has a financial interest in the subject matter in a proceeding or in a party to the proceeding, or has a relationship of director, advisor, or active participant to a party to the proceeding.

(8) The judge, the judge's spouse, a relative of either within the third degree of relationship, or spouse of such relative, is likely to be a material witness.

(9) A party to the action before the judge, or the party's spouse, is related within the third degree of relationship to either the judge or to the judge's spouse.

(10) The judge believes that recusal would further the interests of justice or believes there is a substantial doubt as to his or her capacity to be impartial.

(11) The judge has actual bias against or in favor of an attorney for a party and the judge has a substantial doubt as to his or her capacity to be impartial. A judge is not disqualified as to other members or associates in a law firm, or as to the law firm itself, solely because of actual bias against or in favor of individual attorneys in or associated with the firm. Actual bias in favor of or against an attorney does not in itself create the appearance of bias as to a law firm of which the attorney is a member or associate. A doubt of a person aware of the facts that a judge could be impartial towards a law firm or other members or associates of a law firm, based only on knowledge of a judge's bias in favor of or against an individual attorney or attorneys, is not a doubt which is reasonably entertained. If the workers' compensation appeals board, on a petition for disqualification alleging bias against or in favor of an attorney, determines that a judge is disqualified because of the appearance of bias or because a person aware of the facts might reasonably entertain a doubt that the judge could be impartial, it shall not be presumed, as to a law firm of which the attorney is a member or associate, or as to other members or associates of the law firm:

A. that there is the appearance of bias; or

B. that a person aware of the facts might reasonably entertain a doubt that the judge could be impartial.

(b) The parties may waive the disqualification of a judge after written disclosure of the facts constituting a ground of disqualification. A judge who believes he or she is disqualified shall recuse or shall state in writing the basis of disqualification. All waivers shall be in writing and shall be made part of the file, or shall be made on the record. The judge may ask the parties and their attorneys whether they wish to waive the disqualification. The judge may not request the parties or attorneys to waive the disqualification The parties and any attorney for the employee shall execute any waiver. An attorney for a party other than the employee may execute the waiver on behalf of the attorney's clients. Such a waiver shall state that the attorney has advised the client of the disqualification information, and that the client has agreed to waive the disqualification.

(c) Disqualification for the following circumstances cannot be waived:

(1) The judge, the judge's spouse, a relative of either within the third degree of relationship, or spouse of such relative, is likely to be a material witness

(2) The judge served as a lawyer in the case.

Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New section filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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§9721.13. What Are Not Grounds for Disqualification.

The following factors do not in themselves disqualify a judge:
(a) That the judge is or is not a member of a racial, ethnic, religious, gender, or sexual orientation classification, and the proceedings involve the rights of a person of the same classification.

(b) That the judge has, in any capacity, expressed a view on a legal or factual issue presented in the proceeding, except if the judge has formed or expressed an unqualified opinion or belief as to the merits of the particular action before the judge.

(c) That the judge has a policy of insurance with an insurance company that is a party or is a carrier of a party in the proceeding, unless the judge also has a pending claim or dispute with the insurance company.

(d) That the judge has a currently disputed or recently finalized workers' compensation claim against a party.
Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New section filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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§9721.14. Manner of Disclosure.

(a) Facts or circumstances which are required to be disclosed pursuant to §9721.11 or §9721.12, except for those which must be disclosed pursuant to subdivision (a) of §9721.11, shall be disclosed on the record.

(b) Facts or circumstances which are required to be disclosed pursuant to subdivision (a) of §9721.11 may be disclosed by the judge by providing a list of former clients. The posting in the courtroom of a list of the judge's former clients will satisfy this requirement as to former clients who were not employee workers' compensation claimants. A judge shall not post a list of former clients who were employee workers' compensation claimants, but shall make a list available to the parties in a case, and shall disclose the availability of the list.

Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New section filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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§9721.31. Financial Interests in Educational Programs.

(a) A workers' compensation administrative law judge may not have an ownership interest in, nor may the workers' compensation administrative law judge receive a percentage of revenue or any other contingent economic interest relating to, educational programs servicing the workers' compensation community.

(b) As used in this section, "percentage of revenues or any other contingent financial interest" does not include:
(1) Usual and customary royalties or residuals paid by commercial publishers in the normal course of business, provided that the publisher does not appear before the workers' compensation administrative law judge in question.

(2) Usual and customary royalties or residuals earned by a workers' compensation administrative law judge who self-publishes or owns the company that publishes his or her work, provided that the book is not available for purchase or delivery at any office of the Division of Workers' Compensation and is not sold or distributed by any Division of Workers' Compensation employee on behalf of the workers' administrative law judge. Any workers' compensation administrative law judge who self-publishes or owns the company that publishes his or her work has the responsibility to submit to the Court Administrator, or his or her designee, for approval a proposed plan that complies with this subdivision. If there is no Court Administrator, then the workers' compensation administrative law judge shall submit the proposed plan to the Administrative Director.

Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New section filed 11-30-95; operative 12-1-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 48).

2. Amendment filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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§9721.32. Duty to Report Ethics Violations.

When circumstances warrant, a workers' compensation administrative law judge shall take or initiate appropriate corrective action, which may include reporting to the appropriate authority, in respect to a workers' compensation administrative law judge, lawyer, party, or other person who engages in unprofessional, fraudulent or other improper conduct of which the workers' compensation administrative law judge becomes aware through personal knowledge or based upon information the judge reasonably believes to be competent and reliable.

Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New section filed 11-30-95; operative 12-1-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 48).

2. Amendment of section heading and section filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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§9721.33. Previously Earned Compensation.

A Workers' Compensation Administrative Law Judge may receive previously earned compensation.
Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New section filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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§9722. The Workers' Compensation Ethics Advisory Committee.

(a) There shall be a Workers' Compensation Ethics Advisory Committee consisting of nine members appointed by the Administrative Director or by his/her designee:

(1) a member of the public representing organized labor,

(2) a member of the public representing insurers,

(3) a member of the public representing self-insured employers,

(4) an attorney who formerly practiced before the Workers' Compensation Appeals Board and who usually represented insurers or employers,

(5) an attorney who formerly practiced before the Workers' Compensation Appeals Board and who usually represented applicants,

(6) a presiding workers' compensation administrative law judge,

(7) a workers' compensation administrative law judge or retired workers' compensation administrative law judge,

(8) and (9) two members of the public outside the workers' compensation community.

Members shall serve for a term of four years. However, to create staggered terms, the first term of members in odd-numbered categories above shall be two years. The Administrative Director shall designate a chairperson.

(b) The Committee shall meet as necessary to carry out its responsibilities under this article. State employees shall meet on state time and at state expense.

(c) The Committee may do the following:

(1) Receive complaints made against workers' compensation administrative law judges,

(2) Forward those complaints to the Administrative Director or Court Administrator with a recommendation to investigate or not to investigate,

(3) Monitor the outcome of complaints, and

(4) Make reports and recommendations to the Administrative Director, the Court Administrator, the legislature and the public concerning the integrity of the workers' compensation adjudicatory process. The Committee shall make a public report on or before April 15 or each year, summarizing the activities of the Committee in the previous calendar year. The report shall not contain personally identifiable information concerning complainants or workers' compensation administrative law judges, unless the information is already public.

(d) The Administrative Director shall make staff available to the Committee to assist it in carrying out its functions.

(e) The Committee may receive information that is not available to the public. The Committee shall hold such information strictly confidential from public disclosure. However, this rule of confidentiality shall not prevent the Administrative Director or Court Administrator from disclosing information to the workers' compensation administrative law judge, if the workers' compensation administrative law judge is otherwise entitled to the information.

Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New section filed 11-30-95; operative 12-1-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 48).

2. Amendment filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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§9722.1. Commencing an Investigation.
Complaint About a Workers' Compensation Administrative Law Judge (276K)

(a) Any person may file a complaint concerning an ethics violation by a workers' compensation administrative law judge with the Committee. The Committee or the Administrative Director may require complaints to be filed in a particular form. Nothing in these regulations prohibits any person from complaining directly to a presiding workers' compensation administrative law judge, the Chief Judge, the Court Administrator or to the Administrative Director. The presiding workers' compensation administrative law judge, the Chief Judge, and Court Administrator or the Administrative Director may, but is not required to, refer such complaints to the Committee.

(b) The Committee shall review the complaint. The Committee may make inquiries to obtain information needed to clarify the complaint and/or to obtain additional information necessary to determine if the complaint might have merit.

(c) If the Committee determines that the complaint does not allege facts that might constitute an ethics violation, or if the complaint is merely conjectural or conclusory, specious, obviously unfounded, or stale, or alleges only legal error by the workers' compensation administrative law judge, the Committee shall forward the complaint to the Administrative Director or Court Administrator with a recommendation not to proceed with the complaint.

(d) If the Committee determines that the complaint might have merit, the Committee shall refer the complaint to the Administrative Director or Court Administrator. Complaints against the Administrative Director or Court Administrator shall be referred to the Director of Industrial Relations.

(e) Except as otherwise provided in subdivision (c) of section 9722.2, reports and recommendations of the Committee regarding individual complaints shall remain confidential.

Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New section filed 11-30-95; operative 12-1-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 48).

2. Amendment filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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§9722.2. Investigation and Action by the Administrative Director.

(a) Upon receiving a complaint from the Committee, the Administrative Director or Court Administrator shall investigate whether a workers' compensation administrative law judge has committed an ethics violation.

(b) If the Administrative Director or Court Administrator determines after investigation that misconduct has occurred, he or she shall take appropriate disciplinary or other action against the workers' compensation administrative law judge. The Administrative Director's or Court Administrator's action shall be in the form required by Government Code section 19574 or section 19590(b), or other applicable laws governing the ethics violation.

(c) The Administrative Director or Court Administrator shall provide the Committee with a copy of his or her decision and shall inform the complaining party whether an ethical violation occurred, and whether corrective action was taken.

Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New section filed 11-30-95; operative 12-1-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 48).

2. Amendment of section heading and section filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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§9723. Miscellaneous Provisions.

(a) This article does not replace or diminish the procedural rights of a workers' compensation administrative law judge under the State Civil Service Act. Documentation of unfounded or unsubstantiated complaints shall not be retained in the employee's personnel file.

(b) This article does not replace or diminish the authority of the Administrative Director or Court Administrator to investigate allegations of ethics violations, to impose appropriate discipline, or to take any other action authorized by law.

(c) Nothing in this article shall affect the rights and obligations of the Administrative Director or Court Administrator and workers' compensation administrative law judges concerning the probationary period under Government Code sections 19170 through 19180.

(d) Pursuant to Government Code section 19574.5, the Administrative Director or Court Administrator may place a workers' compensation administrative law judge on leave of absence pending investigation of the accusations listed in that section.

(e) A workers' compensation administrative law judge or other interested person may request the Administrative Director or Court Administrator to issue an advisory opinion on the application of the Code or other rules to a particular situation. The Administrative Director or Court Administrator may, in his or her sole discretion, issue an advisory opinion. The Administrative Director or Court Administrator may issue an advisory opinion on his or her own initiative.

Note: Authority cited: Sections 123.6, 133 and 5307.3, Labor Code. Reference: Sections 111 and 123.6, Labor Code.

HISTORY

1. New section filed 11-30-95; operative 12-1-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 48).

2. Amendment filed 8-25-2008; operative 9-24-2008 (Register 2008, No. 35).

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New query

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§9725. Method of Measurement.

The method of measuring physical elements of a disability should follow the Report of the Joint Committee of the California Medical Association and Industrial Accident Commission, as contained in “Evaluation of Industrial Disability” edited by Packard Thurber, Second Edition, Oxford University Press, New York, 1960. This section shall not apply to any permanent disability evaluations performed pursuant to the permanent disability rating schedule adopted on or after January 1, 2005.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New Subchapter (§§ 9725, 9727, 9732, 9735, 9738, 9739, 9742-9744, 9750, 9753, 9756-9760, 9770, 9773, 9775, 9778, 9784, 9787, 9790, 9796, 9799, 9802 and 9805) filed 4-18-66; effective thirtieth day thereafter (Register 65, No. 10).

2. Amendment of section and Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 12-31-2004 order transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9726. Method of Measurement (Psychiatric).

The method of measuring the psychiatric elements of a disability shall follow the Report of the Subcommittee on Permanent Psychiatric Disability to the Medical Advisory Committee of the California Division of Industrial Accidents, entitled “The Evaluation of Permanent Psychiatric Disability,” (hereinafter referred to as the “Psychiatric Protocols”) as adopted, forwarded for adoption on July 10, 1987, and subsequent amendments and/or revisions thereto adopted after a public hearing. This section shall not apply to any permanent disability evaluations performed pursuant to the permanent disability rating schedule adopted on or after January 1, 2005.

Note: The Report (which contains these Protocols) of the Subcommittee on Permanent Psychiatric Disability, as adopted, does not appear as a printed part of the Administrative Director's Regulations (8 California Code of Regulations, Section 9726); copies will be available through the Medical Director of the Division of Industrial Accidents.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 8-24-87; operative 8-24-87 (Register 87, No. 36). This regulation was filed pursuant to Government Code Section 11351 and thus this filing is exempted from compliance with Article 5 (commencing with Section 11346), (except subdivision (e) of Section 11346.4), Article 6 (commencing with Section 11349), and Article 7 (commencing with Section 11350) of Chapter 3.5 of the Government Code. The provisions of Government Code Section 11343.6 are not applicable to this filing.

2. Amendment filed 6-30-88; operative 7-1-88 (Register 88, No. 28). The amendment was filed pursuant to Government Code Section 11351.

3. Amendment of section and Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 12-31-2004 order transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 2. Disabilities, Description Of

New query

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§9727. Subjective Disability.

Subjective Disability should be identified by:

1. A description of the activity which produces the disability.

2. The duration of the disability.

3. The activities which are precluded and those which can be performed with the disability.

4. The means necessary for relief. The terms shown below are presumed to mean the following:

1. A severe pain would preclude the activity precipitating the pain.

2. A moderate pain could be tolerated, but would cause marked handicap in the performance of the activity precipitating the pain.

3. A slight pain could be tolerated, but would cause some handicap in the performance of the activity precipitating the pain.

4. A minimal (mild) pain would constitute an annoyance, but causing no handicap in the performance of the particular activity, would be considered as nonratable permanent disability.

This section shall not apply to any permanent disability evaluations performed pursuant to the permanent disability rating schedule adopted on or after January 1, 2005.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New last paragraph and new Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23)

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New query

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§9732. Authority. (Repealed)

NOTE: Authority cited: Sections 124, 127, 133, 138.2, 138.3, 138.4, 139, 139.5, 139.6, 4600, 4601, 4602, 4603, 4603.2, 4603.5, 5307.3, 5450, 5451, 5452, 5453, 5454, and 5455, Labor Code. Reference: Chapters 442, 709, and 1172, Statutes of 1977; Chapter 1017, Statutes of 1976.

HISTORY

1. Amendment filed 11-7-78; effective thirtieth day thereafter (Register 78, No. 45).

2. Repealer of article 3 (sections 9732-9766, nonconsecutive) and section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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New query

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§9735. Disability, When Considered Permanent. (Repealed)

HISTORY

1. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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New query

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§9738. Permanent Disability Ratings and Evaluations, Kinds. (Repealed)

HISTORY

1. Amendment filed 11-7-78; effective thirtieth day thereafter (Register 78, No. 45).

2. Amendment filed 10-16-81; effective thirtieth day thereafter (Register 81, No. 42).

3. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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Article 3. Permanent Disability Ratings and Evaluations

New query

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§9739. Formal Ratings. (Repealed)

NOTE: Authority cited: Sections 124, 133 and 5307.3, Labor Code. Reference: Section 124, Labor Code.

HISTORY

1. Change without regulatory effect filed 7-11-86; effective upon filing (Register 86, No. 28).

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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New query

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§9742. Informal Ratings. (Repealed)

NOTE: Authority cited: Sections 124, 5307.3 and 5451, Labor Code. Reference: Sections 124, 5451 and 5453, Labor Code.

HISTORY

1. Amendment filed 12-8-69; designated effective 1-1-70 (Register 69, No. 50).

2. Amendment filed 11-7-78; effective thirtieth day thereafter (Register 78, No. 45).

3. Amendment filed 10-16-81; effective thirtieth day thereafter (Register 81, No. 42).

4. Amendment filed 7-15-83; effective thirtieth day thereafter (Register 83, No. 30).

5. Editorial correction of 7-15-83 order redesignating effective date to 8-1-83 pursuant to Government Code Section 11346.2(d) filed 7-19-83 (Register 83, No. 30).

6. Amendment filed 8-29-84; effective thirtieth day thereafter (Register 84, No. 35).

7. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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New query

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§9743. Form DIA 200, Employee's Request for Informal Permanent Disability Rating. (Repealed)

NOTE: Authority cited: Sections 124 and 5307.3, Labor Code. Reference: Section 124, Labor Code.

HISTORY

1. Amendment filed 11-7-78; effective thirtieth day thereafter (Register 78, No. 45).

2. Amendment filed 10-16-81; effective thirtieth day thereafter (Register 81, No. 42).

3. Repealer filed 7-15-83; effective thirtieth day thereafter (Register 83, No. 30).

4. Editorial correction of 7-15-83 order redesignating effective date to 8-1-83 pursuant to Government Code Section 11346.2(d) filed 7-19-83 (Register 83, No. 30).

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New query

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§9744. Form DIA 201, Insurance Carrier's or Self-Insurer's Request for Informal Permanent Disability Rating. (Repealed)

NOTE: Authority cited: Sections 124 and 5307.3, Labor Code. Reference: Section 124, Labor Code.

HISTORY

1. Amendment filed 11-7-78; effective thirtieth day thereafter (Register 78, No. 45).

2. Amendment filed 10-16-81; effective thirtieth day thereafter (Register 81, No. 42).

3. Repealer filed 7-15-83; effective thirtieth day thereafter (Register 83, No. 30).

4. Editorial correction of 7-15-83 order redesignating effective date to 8-1-83 pursuant to Government Code Section 11346.2(d) filed 7-19-83 (Register 83, No. 30).

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New query

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§9750. Permanent Disability Rating Reports. (Repealed)

NOTE: Authority cited: Sections 124, 133 and 5307.3, Labor Code. Reference: Section 124, Labor Code.

HISTORY

1. Change without regulatory effect filed 7-11-86; effective upon filing (Register 86, No. 28).

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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New query

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§9753. Informal Ratings, Attorney Fee. (Repealed)

HISTORY

1. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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New query

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§9756. Permanent Disability Evaluations, Kinds. (Repealed)

HISTORY

1. Repealer filed 10-16-81; effective thirtieth day thereafter (Register 81, No. 42).

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New query

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§9757. Pretrial Evaluations. (Repealed)

NOTE: Authority cited: Sections 124 and 5307.3, Labor Code. Reference: Section 124, Labor Code.

HISTORY

1. Amendment filed 10-16-81; effective thirtieth day thereafter (Register 81, No. 42.)

2. Change without regulatory effect filed 7-11-86; effective upon filing (Register 86, No. 28).

3. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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New query

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§9758. Consultative Evaluations. (Repealed)

NOTE: Authority cited: Sections 124, 5307.3 and 5451, Labor Code. Reference: Sections 123.7, 124 and 5453, Labor Code.

HISTORY

1. Amendment filed 12-14-72; designated effective 1-1-73 (Register 72, No. 51).

2. Amendment filed 11-7-78; effective thirtieth day thereafter (Register 78, No. 45).

3. Amendment filed 10-16-81; effective thirtieth day thereafter (Register 81, No. 42).

4. Amendment filed 7-15-83; effective thirtieth day thereafter (Register 83, No. 30).

5. Editorial correction of 7-15-83 order redesignating effective date to 8-1-83 pursuant to Government Code Section 11346.2(d) filed 7-19-83 (Register 83, No. 30).

6. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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- See labor statistics
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LINKS

- Industrial Relations databases
- California Labor & Workforce Development Agency
- Economic & Employment Enforcement Coalition
- Employment Development Department
- Sweat-Free Code of Conduct
- U.S. Dept. of Labor

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New query

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§9760. Summary Evaluations. (Repealed)

HISTORY

1. Repealer filed 10-16-81; effective thirtieth day thereafter (Register 81, No. 42).

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New query

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§9766. Records, Destruction Of. (Repealed)

NOTE: Authority cited: Sections 124, 127, 133, 138.2, 138.3, 138.4, 139, 139.5, 139.6, 4600, 4601, 4602, 4603, 4603.2, 4603.5, 5307.3, 5450, 5451, 5452, 5453, 5454 and 5455, Labor Code. Reference: Section 124, Labor Code; and Section 14755, Government Code.

HISTORY

1. New section filed 6-27-66; effective thirtieth day thereafter (Register 66, No. 20).

2. Amendment of subsection (a) filed 11-7-7; effective thirtieth day thereafter (Register 78, No. 45).

3. Amendment filed 7-15-83; effective thirtieth day thereafter (Register 83, No. 30).

4. Editorial correction of 7-15-83 order redesignating effective date to 8-1-83 pursuant to Government Code Section 11346.2(d) filed 7-19-83 (Register 83, No. 30).

5. Change without regulatory effect of subsections (a) and (b) filed 7-11-86; effective upon filing (Register 86, No. 28).

6. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 3.5. Medical Provider Networks

New query

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§9767.1. Medical Provider Networks -- Definitions.

(a) As used in this article:

(1) "Ancillary services" means any provision of medical services or goods as allowed in Labor Code section 4600 by a non-physician.

(2) "Cessation of use" means the discontinued use of an implemented MPN that continues to do business.

(3) "Covered employee" means an employee or former employee whose employer has ongoing workers' compensation obligations and whose employer or employer's insurer has established a Medical Provider Network for the provision of medical treatment to injured employees unless:

(A) the injured employee has properly designated a personal physician pursuant to Labor Code section 4600(d) by notice to the employer prior to the date of injury, or;

(B) the injured employee's employment with the employer is covered by an agreement providing medical treatment for the injured employee and the agreement is validly established under Labor Code section 3201.5, 3201.7 and/or 3201.81.

(4) "Division" means the Division of Workers' Compensation.

(5) "Economic profiling" means any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.

(6) "Emergency health care services" means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

(7) "Employer" means a self-insured employer, the Self-Insurer's Security Fund, a group of self-insured employers pursuant to Labor Code section 3700(b) and as defined by Title 8, California Code of Regulations, section 15201(s), a joint powers authority, or the state.

(8) "Group Disability Insurance Policy" means an entity designated pursuant to Labor Code section 4616.7(c).

(9) "Health Care Organization" means an entity designated pursuant to Labor Code section 4616.7(a).

(10) "Health Care Service Plan" means an entity designated pursuant to Labor Code section 4616.7(b).

(11) "Insurer" means an insurer admitted to transact workers' compensation insurance in the state of California, California Insurance Guarantee Association, or the State Compensation Insurance Fund.

(12) "Medical Provider Network" ("MPN") means any entity or group of providers approved as a Medical Provider Network by the Administrative Director pursuant to Labor Code sections 4616 to 4616.7 and this article.

(13) "Medical Provider Network Plan" means an employer's or insurer's detailed description for a medical provider network contained in an application submitted to the Administrative Director by a MPN applicant.

(14) "MPN Applicant" means an insurer or employer as defined in subdivisions (7) and (11) of this section.

(15) "MPN Contact" means an individual(s) designated by the MPN Applicant in the employee notification who is responsible for answering employees' questions about the Medical Provider Network and is responsible for assisting the employee in arranging for an independent medical review.

(16) "Nonoccupational Medicine" means the diagnosis or treatment of any injury or disease not arising out of and in the course of employment.

(17) "Occupational Medicine" means the diagnosis or treatment of any injury or disease arising out of and in the course of employment.

(18) "Physician primarily engaged in treatment of nonoccupational injuries" means a provider who spends more than 50 percent of his/her practice time providing non-occupational medical services.

(19) "Primary treating physician" means a primary treating physician within the medical provider network and as defined by section 9785(a)(1).

(20) "Provider" means a physician as described in Labor Code section 3209.3 or other provider as described in Labor Code section 3209.5.

(21) "Regional area listing" means either:

(A) a listing of all MPN providers within a 15-mile radius of an employee's worksite and/or residence; or

(B) a listing of all MPN providers in the county where the employee resides and/or works if

1. the employer or insurer cannot produce a provider listing based on a mile radius

2. or by choice of the employer or insurer, or upon request of the employee.

(C) If the listing described in either (A) or (B) does not provide a minimum of three physicians of each specialty, then the listing shall be expanded by adjacent counties or by 5-mile increments until the minimum number of physicians per specialty are met.

(22) "Residence" means the covered employee's primary residence.

(23) "Second Opinion" means an opinion rendered by a medical provider network physician after an in person examination to address an employee's dispute over either the diagnosis or the treatment prescribed by the treating physician.

(24) "Taft-Hartley health and welfare fund" means an entity designated pursuant to Labor Code section 4616.7(d).

(25) "Termination" means the discontinued use of an implemented MPN that ceases to do business.

(26) "Third Opinion" means an opinion rendered by a medical provider network physician after an in person examination to address an employee's dispute over either the diagnosis or the treatment prescribed by either the treating physician or physician rendering the second opinion.

(27) "Treating physician" means any physician within the MPN applicant's medical provider network other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee.

(28) "Workplace" means the geographic location where the covered employee is regularly employed.

Note: Authority cited: Sections 133 and 4616(g), Labor Code. Reference: Sections 1063.1, 3208, 3209.3, 3209.5, 3700, 3702, 3743, 4616, 4616.1, 4616.3, 4616.5 and 4616.7, Labor Code; andCalifornia Insurance Guarantee Association v. Division of Workers' Compensation (April 26, 2005) WCAB No. Misc. #249.

HISTORY

1. New article 3.5 (sections 9767.1-9767.14) and section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New article 3.5 (sections 9767.1-9767.14) and section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.

3. New article 3.5 (sections 9767.1-9767.14) and section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including amendment of section andNote, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register2005, No. 36).
5. New subsections (a)(2) and (a)(25), subsection renumbering and amendment of newly designated subsection (a)(14) filed 12-11-2007; operative 4-9-2008 (Register 2007, No. 50).

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Article 3.5. Medical Provider Networks

New query

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§9767.2. Review of Medical Provider Network Application.

(a) Within 60 days of the Administrative Director's receipt of a complete application, the Administrative Director shall approve or disapprove an application based on the requirements of Labor Code section 4616 et seq. and this article. An application shall be considered complete if it includes information responsive to each applicable subdivision of section 9767.3. Pursuant to Labor Code section 4616(b), if the Administrative Director has not acted on a plan within 60 days of submittal of a complete plan, it shall be deemed approved.

(b) The Administrative Director shall provide notification(s) to the MPN applicant: (1) setting forth the date the MPN application was received by the Division; and (2) informing the MPN applicant if the MPN application is not complete and the item(s) necessary to complete the application.

(c) No additional materials shall be submitted by the MPN applicant or considered by the Administrative Director until the MPN applicant receives the notification described in (b).

(d) The Administrative Director's decision to approve or disapprove an application shall be limited to his/her review of the information provided in the application.

(e) Upon approval of the Medical Provider Network Plan, the MPN applicant shall be assigned a MPN approval number.

NOTE

Authority cited: Sections 133 and 4616(g), Labor Code. Reference: Section 4616, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including new subsection (c) and subsection relettering, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

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New query

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§9767.3. Application for a Medical Provider Network Plan.

(a) As long as the application for a medical provider network plan meets the requirements of Labor Code section 4616 et seq. and this article, nothing in this section precludes an employer or insurer from submitting for approval one or more medical provider network plans in its application.

(b) Nothing in this section precludes an insurer and an insured employer from agreeing to submit for approval a medical provider network plan which meets the specific needs of an insured employer considering the experience of the insured employer, the common injuries experienced by the insured employer, the type of occupation and industry in which the insured employer is engaged and the geographic area where the employees are employed.

(c) All MPN applicants shall submit an original Cover Page for Medical Provider Network Application with original signature, an original application, and a copy of the Cover Page for Medical Provider Network and application to the Division.

(1) A MPN applicant shall submit the provider information and/or ancillary service provider information required in section 9767.3(d)(8)(C) and (D) on a computer disk(s) or CD ROM(s). The information shall be submitted as a Microsoft Excel spread sheet unless an alternative format is approved by the Administrative Director.

(2) If the network provider information is submitted on a disk(s) or CD ROM(s), the provider file must have only the following three columns. These columns shall be: (1) physician name (2) specialty and (3) location of each physician. By submission of its provider listing, the Applicant is affirming that all of the physicians listed have a valid and current license number to practice in the State of California.

(3) The ancillary service provider file must have only the following three columns. The columns shall be (1) the name of the each ancillary provider (2) specialty or type of service and (3) location of each ancillary service provider. By submission of an ancillary provider listing, the Applicant is affirming that the providers listed have a current valid license number to practice, if they are required to have a license by the State of California.

(d) If the network is not a Health Care Organization, Health Care Service Plan, Group Disability Insurance Policy, or Taft-Hartley Health and Welfare Fund, a Medical Provider Network application shall include all of the following information:

(1) Type of MPN Applicant: Insurer or Employer.

(2) Name of MPN Applicant.

(3) MPN Applicant's Taxpayer Identification Number.

(4) Name of Medical Provider Network, if applicable.

(5) Division Liaison: Provide the name, title, address, e-mail address, and telephone number of the person designated as the liaison for the Division, who is responsible for receiving compliance and informational communications from the Division and for disseminating the same within the MPN.

(6) The application must be verified by an officer or employee of the MPN applicant with the authority to act on behalf of the MPN applicant with respect to the MPN. The verification by the authorized individual shall state: “I, the undersigned officer or employee of the MPN applicant, have read and signed this application and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this application is true and correct.”

(7) Nothing in this section precludes a network, entity, administrator, or other third-party, upon agreement with a MPN applicant, from preparing a MPN application on behalf of an insurer or employer.

(8) Description of Medical Provider Network Plan:

(A) State the number of employees expected to be covered by the MPN plan;

(B) Describe the geographic service area or areas within the State of California to be served;

(C) The name, specialty, and location of each physician as described in Labor Code Section 3209.3, or other providers as described in Labor Code Section 3209.5, who will be providing occupational medicine services under the plan. By submission of the application, the MPN applicant is confirming that a contractual agreement exists with the physicians, providers or medical group practice in the MPN to provide treatment for injured workers in the workers' compensation system and that the contractual agreement is in compliance with Labor Code section 4609, if applicable.

(D) The name, specialty or type of service and location of each ancillary service, other than a physician or provider covered under subdivision (d)(8)(C) of this section, who will be providing medical services within the medical provider network. By submission of the application, the MPN applicant is confirming that a contractual agreement exists with the ancillary service providers to provide services to be used under the MPN;

(E) Describe how the MPN complies with the second and third opinion process set forth in section 9767.7;

(F) Describe how the MPN complies with the goal of at least 25% of physicians (not including pediatricians, OB/GYNs, or other specialties not likely to routinely provide care for common injuries and illnesses expected to be encountered in the MPN) primarily engaged in the treatment of nonoccupational injuries;

(G) Describe how the MPN arranges for providing ancillary services to its covered employees. Set forth which ancillary services, if any, will be within the MPN. For ancillary services not within the MPN, affirm that referrals will be made to services outside the MPN;

(H) Describe how the MPN complies with the access standards set forth in section 9767.5 for all covered employees;

(I) Describe the employee notification process, and attach an English and Spanish sample of the employee notification material described in sections 9767.12(d) and (g). Any specific MPN contact or provider listing access information that is not available for administrative review in the sample employee notification shall be included in the MPN employee notification distributed to employees;

(J) Attach a copy of the written continuity of care policy as described in Labor Code section 4616.2;

(K) Attach a copy of the written transfer of care policy that complies with section 9767.9;

(L) Attach any policy or procedure that is used by the MPN applicant or an entity contracted with the MPN or MPN applicant to conduct “economic profiling of MPN providers” pursuant to Labor Code section 4616.1 and affirm that a copy of the policy or procedure has been provided to the MPN providers or attach a statement that the MPN applicant does not conduct economic profiling of MPN providers;

(M) Provide an affirmation that the physician compensation is not structured in order to achieve the goal of reducing, delaying, or denying medical treatment or restricting access to medical treatment; and

(N) Describe how the MPN applicant will ensure that no person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, when these services are within the scope of the physician's practice, will modify, delay, or deny requests for authorization of medical treatment.

(e) If the entity is a Health Care Organization, a Medical Provider Network application shall set forth the following:

(1) Type of MPN Applicant: Insurer or Employer

(2) Name of MPN Applicant

(3) MPN Applicant's Taxpayer Identification Number

(4) Name of Medical Provider Network, if applicable.

(5) Division Liaison: Provide the name, title, address, e-mail address, and telephone number of the person designated as the liaison for the Division, who is responsible for receiving compliance and informational communications from the Division and for disseminating the same within the MPN.

(6) The application must be verified by an officer or employee of the MPN applicant with the authority to act on behalf of the MPN applicant with respect to the MPN. The verification by the authorized individual shall state: “I, the undersigned officer or employee of the MPN applicant, have read and signed this application and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this application is true and correct.”

(7) Nothing in this section precludes a network, entity, administrator, or other third-party, upon agreement with a MPN applicant, from preparing a MPN application on behalf of an insurer or employer.

(8) Describe how the MPN complies with the second and third opinion process set forth in section 9767.7;

(9) Confirm that the application shall set forth that at least 25% of the network physicians are primarily engaged in nonoccupational medicine;

(10) Describe the geographic service area or areas within the State of California to be served and affirm that this access plan complies with the access standards set forth in section 9767.5;

(11) Describe the employee notification process, and attach an English and Spanish sample of the employee notification material described in sections 9767.12(d) and (g). Any specific MPN contact or provider listing access information that is not available for administrative review in the sample employee notification shall be included in the MPN employee notification distributed to employees;

(12) Attach a copy of the written continuity of care policy as described in Labor Code section 4616.2;

(13) Attach a copy of the written transfer of care policy that complies with section 9767.9 with regard to the transfer of on-going cases from the HCO to the MPN;

(14) Attach a copy of the policy or procedure that is used by the MPN applicant or an entity contracted with the MPN or MPN applicant to conduct “economic profiling of MPN providers” pursuant to Labor Code section 4616.1 and affirm that a copy of the policy or procedure has been provided to the MPN providers or attach a statement that the MPN applicant does not conduct economic profiling of MPN providers; and

(15) Describe the number of employees expected to be covered by the MPN plan and confirm that the number of employees is within the approved capacity of the HCO.

(16) By submission of the application, the MPN applicant is confirming that a contractual agreement exists with the physicians, providers or medical group practice in the MPN to provide treatment for injured workers in the workers' compensation system and that the contractual agreement with the providers is in compliance with Labor Code section 4609, if applicable.

(f) If the entity is a Health Care Service Plan, Group Disability Insurance Policy, or Taft-Hartley Health and Welfare Fund, in addition to the requirements set forth in subdivision (e) [excluding (e)(9) and (e)(15)] of this section, a Medical Provider Network application shall include the following information:

(1) The application shall set forth that the entity has a reasonable number of providers with competency in occupational medicine.

(A) The MPN applicant may show that a physician has competency by confirming that the physician either is Board Certified or was residency trained in that specialty.

(B) If (A) is not applicable, describe any other relevant procedure or process that assures that providers of medical treatment are competent to provide treatment for occupational injuries and illnesses.

(g) If the MPN applicant is providing for ancillary services within the MPN that are in addition to the services provided by the Health Care Organization, Health Care Service Plan, Group Disability Insurance Policy, or Taft-Hartley Health and Welfare Fund, it shall set forth the ancillary services in the application.

(h) If a Health Care Organization, Health Care Service Plan, Group Disability Insurance Policy, or Taft-Hartley Health and Welfare Fund has been approved as a MPN, and the entity does not maintain its certification or licensure or regulated status, then the entity must file a new Medical Provider Network Application pursuant to section 9767.3(d).

(i) If a Health Care Organization, Health Care Service Plan, Group Disability Insurance Policy, or Taft-Hartley Health and Welfare Fund has been modified from its certification or licensure or regulated status, the application shall comply with subdivision (d) of this section.

Note: Authority cited: Sections 133 and 4616(g), Labor Code. Reference: Sections 3209.3, 4609, 4616, 4616.1, 4616.2, 4616.3, 4616.5 and 4616.7, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law

on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including amendment of section and Note, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

5. Amendment of subsections (c)(1)-(3), (d)(6)-(7), (d)(8)(C)-(D), (d)(8)(I), (d)(8)(L), (e)(6)-(7), (e)(11), (e)(14), (f) and (i) filed 8-9-2010; operative 10-8-2010 (Register 2010, No. 33).

6. Change without regulatory effect amending subsections (c)(1), (d)(8)(I) and (e)(11) filed 9-23-2010 pursuant to section 100, title 1, California Code of Regulations (Register 2010, No. 39).

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New query

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§9767.4. Cover Page for Medical Provider Network Application

View Graphic

NOTE

Note: Authority cited: Sections 133 and 4616(g), Labor Code. Reference: Sections 3700, 3743, 4616, 4616.5 and 4616.7, Labor Code.

HISTORY 1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3- 1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6- 29-2005 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10- 27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including amendment of section and Note, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

5. Change without regulatory effect amending section filed 5-23-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 21).

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§9767.5. Access Standards

(a) A MPN must have at least three physicians of each specialty expected to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged and within the access standards set forth in (b) and (c).

(b) A MPN must have a primary treating physician and a hospital for emergency health care services, or if separate from such hospital, a provider of all emergency health care services, within 30 minutes or 15 miles of each covered employee's residence or workplace.

(c) A MPN must have providers of occupational health services and specialists within 60 minutes or 30 miles of a covered employee's residence or workplace.

(d) If a MPN applicant believes that, given the facts and circumstances with regard to a portion of its service area, specifically rural areas including those in which health facilities are located at least 30 miles apart, the accessibility standards set forth in subdivisions (b) and/or (c) are unreasonably restrictive, the MPN applicant may propose alternative standards of accessibility for that portion of its service area. The MPN applicant shall do so by including the proposed alternative standards in writing in its plan approval application or in a notice of MPN plan modification. The alternative standards shall provide that all services shall be available and accessible at reasonable times to all covered employees.

(e)(1) The MPN applicant shall have a written policy for arranging or approving non-emergency medical care for: (A) a covered employee authorized by the employer to temporarily work or travel for work outside the MPN geographic service area when the need for medical care arises; (B) a former employee whose employer has ongoing workers' compensation obligations and who permanently resides outside the MPN geographic service area; and (C) an injured employee who decides to temporarily reside outside the MPN geographic service area during recovery.

(2) The written policy shall provide the employees described in subdivision (e)(1) above with the choice of at least three physicians outside the MPN geographic service area who either have been referred by the employee's primary treating physician within the MPN or have been selected by the MPN applicant. In addition to physicians within the MPN, the employee may change physicians among the referred physicians and may obtain a second and third opinion from the referred physicians.

(3) The referred physicians shall be located within the access standards described in paragraphs (c) and (d) of this section.

(4) Nothing in this section precludes a MPN applicant from having a written policy that allows a covered employee

outside the MPN geographic service area to choose his or her own provider for non-emergency medical care.

(f) For non-emergency services, the MPN applicant shall ensure that an appointment for initial treatment is available within 3 business days of the MPN applicant's receipt of a request for treatment within the MPN.

(g) For non-emergency specialist services to treat common injuries experienced by the covered employees based on the type of occupation or industry in which the employee is engaged, the MPN applicant shall ensure that an appointment is available within 20 business days of the MPN applicant's receipt of a referral to a specialist within the MPN.

(h) If the primary treating physician refers the covered employee to a type of specialist not included in the MPN, the covered employee may select a specialist from outside the MPN.

(i) The MPN applicant shall have a written policy to allow an injured employee to receive emergency health care services from a medical service or hospital provider who is not a member of the MPN.

NOTE

Authority cited: Sections 133 and 4616(g), Labor Code. Reference: Sections 4616 and 4616.3, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including amendment of section, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

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§9767.6. Treatment and Change of Physicians Within MPN

(a) When the injured covered employee notifies the employer or insured employer of the injury or files a claim for workers' compensation with the employer or insured employer, the employer or insurer shall arrange an initial medical evaluation with a MPN physician in compliance with the access standards set forth in section 9767.5.

(b) Within one working day after an employee files a claim form under Labor Code section 5401, the employer or insurer shall provide for all treatment, consistent with guidelines adopted by the Administrative Director pursuant to Labor Code section 5307.27 and as set forth in title 8, California Code of Regulations, section 9792.20 et seq.

(c) The employer or insurer shall provide for the treatment with MPN providers for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is rejected. Until the date the claim is rejected, liability for the claim shall be limited to ten thousand dollars ($10,000).

(d) The insurer or employer shall notify the employee of his or her right to be treated by a physician of his or her choice within the MPN after the first visit with the MPN physician and the method by which the list of participating providers may be accessed by the employee.

(e) At any point in time after the initial medical evaluation with a MPN physician, the covered employee may select a physician of his or her choice from within the MPN. Selection by the covered employee of a treating physician and any subsequent physicians shall be based on the physician's specialty or recognized expertise in treating the particular injury or condition in question.

(f) A Petition for Change of Treating Physician, as set forth at section 9786, cannot be utilized to seek a change of physician for a covered employee who is treating with a physician within the MPN.

Note: Authority cited: Sections 133 and 4616(g), Labor Code. Reference: Sections 4604.5, 4616, 4616.3, 5307.27 and 5401, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including amendment of section, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

5. Amendment of subsections (b) and (f) filed 8-9-2010; operative 10-8-2010 (Register 2010, No. 33).

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§9767.7. Second and Third Opinions

(a) If the covered employee disputes either the diagnosis or the treatment prescribed by the primary treating physician or the treating physician, the employee may obtain a second and third opinion from physicians within the MPN. During this process, the employee is required to continue his or her treatment with the treating physician or a physician of his or her choice within the MPN.

(b) If the covered employee disputes either the diagnosis or the treatment prescribed by primary treating physician or the treating physician, it is the employee's responsibility to: (1) inform the person designated by the employer or insurer that he or she disputes the treating physician's opinion and requests a second opinion (the employee may notify the person designated by the employer or insurer either in writing or orally); (2) select a physician or specialist from a list of available MPN providers; (3) make an appointment with the second opinion physician within 60 days; and (4) inform the person designated by the employer or insurer of the appointment date. It is the employer's or insurer's responsibility to (1) provide a regional area listing of MPN providers and/or specialists to the employee for his/her selection based on the specialty or recognized expertise in treating the particular injury or condition in question and inform the employee of his or her right to request a copy of the medical records that will be sent to the second opinion physician; (2) contact the treating physician, provide a copy of the medical records or send the necessary medical records to the second opinion physician prior to the appointment date, and provide a copy of the records to the covered employee upon request; and (3) notify the second opinion physician in writing that he or she has been selected to provide a second opinion and the nature of the dispute with a copy to the employee. If the appointment is not made within 60 days of receipt of the list of the available MPN providers, then the employee shall be deemed to have waived the second opinion process with regard to this disputed diagnosis or treatment of this treating physician.

(c) If, after reviewing the covered employee's medical records, the second opinion physician determines that the employee's injury is outside the scope of his or her practice, the physician shall notify the person designated by the employer or insurer and employee so the employer or insurer can provide a new list of MPN providers and/or specialists to the employee for his/her selection based on the specialty or recognized expertise in treating the particular injury or condition in question.

(d) If the covered employee disagrees with either the diagnosis or treatment prescribed by the second opinion physician, the injured employee may seek the opinion of a third physician within the MPN. It is the employee's responsibility to: (1) inform the person designated by the employer or insurer that he or she disputes the treating physician's opinion and requests a third opinion (the employee may notify the person designated by the employer or insurer either in writing or orally); (2) select a physician or specialist from a list of available MPN providers; and (3)

make an appointment with the third opinion physician within 60 days; and (4) inform the person designated by the employer or insurer of the appointment date. It is the employer's or insurer's responsibility to (1) provide a regional area listing of MPN providers and/or specialists to the employee for his/her selection based on the specialty or recognized expertise in treating the particular injury or condition in question and inform the employee of his or her right to request a copy of the medical records that will be sent to the third opinion physician; and (2) contact the treating physician, provide a copy of the medical records or send the necessary medical records to the third opinion physician prior to the appointment date, and provide a copy of the records to the covered employee upon request; and (3) notify the third opinion physician in writing that he or she has been selected to provide a third opinion and the nature of the dispute with a copy to the employee. If the appointment is not made within 60 days of receipt of the list of the available MPN providers, then the employee shall be deemed to have waived the third opinion process with regard to this disputed diagnosis or treatment of this treating physician.

(e) If, after reviewing the covered employee's medical records, the third opinion physician determines that the employee's injury is outside the scope of his or her practice, the physician shall notify the person designated by the employer or insurer and employee so the MPN can provide a new list of MPN providers and/or specialists to the employee for his/her selection based on the specialty or recognized expertise in treating the particular injury or condition in question.

(f) The second and third opinion physicians shall each render his or her opinion of the disputed diagnosis or treatment in writing and offer alternative diagnosis or treatment recommendations, if applicable. Any recommended treatment shall be in accordance with Labor Code section 4616(e). The second and third opinion physicians may order diagnostic testing if medically necessary. A copy of the written report shall be served on the employee, the person designated by the employer or insurer, and the treating physician within 20 days of the date of the appointment or receipt of the results of the diagnostic tests, whichever is later.

(g) The employer or insurer shall permit the employee to obtain the recommended treatment within the MPN. The covered employee may obtain the recommended treatment by changing physicians to the second opinion physician, third opinion physician, or other MPN physician.

(h) If the injured covered employee disagrees with the diagnosis or treatment of the third opinion physician, the injured employee may file with the Administrative Director a request for an Independent Medical Review.

NOTE

Authority cited: Sections 133 and 4616(g), Labor Code. Reference: Sections 4616(a) and 4616.3, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including amendment of section, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

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§9767.8. Modification of Medical Provider Network Plan

Notice of medical provider network plan modification Labor Code 9767.8

(a) The MPN applicant shall serve the Administrative Director with an original Notice of MPN Plan Modification with original signature, any necessary documentation, and a copy of the Notice and any necessary documentation before any of the following changes occur:

(1) A change of 10% or more in the number or specialty of providers participating in the network since the approval date of the previous MPN Plan application or modification.

(2) A change of 25% or more in the number of covered employees since the approval date of the previous MPN Plan application or modification.

(3) A material change in the continuity of care policy.

(4) A material change in the transfer of care policy.

(5) Change in policy or procedure that is used by the MPN or an entity contracted with the MPN or MPN applicant to conduct “economic profiling of MPN providers” pursuant to Labor Code section 4616.1.

(6) Change in the name of the MPN or the MPN Applicant.

(7) Change in geographic service area within the State of California.

(8) Change in how the MPN complies with the access standards.

(9) A material change in any of the employee notification materials, including a change in MPN contact information or a change in provider listing access or website information, required by section 9767.12.

(10) Change in use of one of the following deemed entities: Health Care Organization (HCO), Health Care Service Plan, Group Disability Insurer, or Taft-Hartley Health and Welfare Trust Fund.

(11) Revision of any plan section(s) required by sections 9767.3(d)(8) or 9767.3(e) due to a change of any MPN administrator(s) listed in the MPN Plan.

(12) Replacement of entire MPN plan application.

(13) Updating to the permanent regulations pursuant to section 9767.15.

(b) The MPN applicant shall serve the Administrative Director with a Notice of MPN Plan Modification within 5 business days of a change of the DWC liaison or authorized individual.

(c) The modification must be verified by an officer or employee of the MPN with the authority to act on behalf of the MPN applicant with respect to the MPN. The verification by the authorized individual shall state: “I, the undersigned officer or employee of the MPN applicant, have read and signed this notice and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this notice is true and correct.”

(d) Within 60 days of the Administrative Director's receipt of a Notice of MPN Plan Modification, the Administrative Director shall approve or disapprove the plan modification based on information provided in the Notice of MPN Plan Modification. The Administrative Director shall approve or disapprove a plan modification based on the requirements of Labor Code section 4616 et seq. and this article. If the Administrative Director has not acted on a plan within 60 days of submittal of a Notice of MPN Plan Modification, it shall be deemed approved. Except for subdivisions (a)(6) and (b) of this section, modifications shall not be made until the Administrative Director has approved the plan or until 60 days have passed, which ever occurs first. If the Administrative Director disapproves of the MPN plan modification, he or she shall serve the MPN applicant with a Notice of Disapproval within 60 days of the submittal of a Notice of MPN Plan Modification.

(e) A MPN applicant denied approval of a MPN plan modification may either:

(1) Submit a new request addressing the deficiencies; or

(2) Request a re-evaluation by the Administrative Director.

(f) Any MPN applicant may request a re-evaluation of the denial by submitting with the Division, within 20 days of the issuance of the Notice of Disapproval, a written request for a re-evaluation with a detailed statement explaining the basis upon which a re-evaluation is requested. The request for re-evaluation shall be accompanied by supportive documentary material relevant to the specific allegations raised and shall be verified under penalty of perjury. The MPN application and modification at issue shall not be refiled; they shall be made part of the administrative record by incorporation by reference.

(g) The Administrative Director shall, within 45 days of the receipt of the request for a re-evaluation, either:

(1) Issue a Decision and Order affirming or modifying the Notice of Disapproval based on a failure to meet the procedural requirements of this section or based on a failure to meet the requirements of Labor Code section 4616 et seq. and this article; or

(2) Issue a Decision and Order revoking the Notice of Disapproval and issue an approval of the modification.

(h) The Administrative Director may extend the time specified in subdivision (h) within which to act upon the request for a re-evaluation for a period of 30 days and may order a party to submit additional documents or information.

(i) A MPN applicant may appeal the Administrative Director's decision and order regarding the MPN by filing, within twenty (20) days of the issuance of the decision and order, a petition at the district office of the Workers' Compensation Appeals Board closest to the MPN applicant's principal place of business, together with a Declaration of Readiness to Proceed. The petition shall set forth the specific factual and/or legal reason(s) for the appeal. A copy of the petition and of the Declaration of Readiness to Proceed shall be concurrently served on the Administrative Director.

(j) The MPN applicant shall use the following Notice of MPN Plan Modification form:

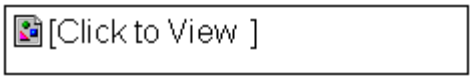

Image 1 (5.85" X 7.6") Available for Offline Print

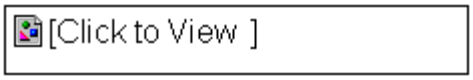

Image 2 (5.82" X 3.54") Available for Offline Print

Note: Authority cited: Sections 133, 4616(g) and 5300(f), Labor Code. Reference: Sections 3700, 3743, 4616, 4616.2 and 4616.5, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including amendment of section and Note, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

5. Change without regulatory effect amending form filed 5-23-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 21).

6. Amendment of subsections (a)(5)-(6) and (a)(9), new subsections (a)(10)-(13) and amendment of subsections (b)-(d), (g)(2) and (j) filed 8-9-2010; operative 10-8-2010 (Register 2010, No. 33).

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§9767.9. Transfer of Ongoing Care into the MPN.

(a) If the injured covered employee's injury or illness does not meet the conditions set forth in (e)(1) through (e)(4), the injured covered employee may be transferred into the MPN for medical treatment.

(b) Until the injured covered employee is transferred into the MPN, the employee's physician may make referrals to providers within or outside the MPN.

(c) Nothing in this section shall preclude an insurer or employer from agreeing to provide medical care with providers outside of the MPN.

(d) If an injured covered employee is being treated for an occupational injury or illness by a physician or provider prior to coverage of a medical provider network, and the injured covered employee's physician or provider becomes a provider within the MPN that applies to the injured covered employee, then the employer or insurer shall inform the injured covered employee and his or her physician or provider if his/her treatment is being provided by his/her physician or provider under the provisions of the MPN.

(e) The employer or insurer shall authorize the completion of treatment for injured covered employees who are being treated outside of the MPN for an occupational injury or illness that occurred prior to the coverage of the MPN and whose treating physician is not a provider within the MPN, including injured covered employees who pre-designated a physician and do not fall within the Labor Code section 4600(d), for the following conditions:

(1) An acute condition. For purposes of this subdivision, an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a duration of less than 90 days. Completion of treatment shall be provided for the duration of the acute condition.

(2) A serious chronic condition. For purposes of this subdivision, a serious chronic condition is a medical condition due to a disease, illness, catastrophic injury, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over 90 days and requires ongoing treatment to maintain remission or prevent deterioration. Completion of treatment shall be authorized for a period of time necessary, up to one year: (A) to complete a course of treatment approved by the employer or insurer; and (B) to arrange for transfer to another provider within the MPN, as determined by the insurer or employer. The one year period for completion of treatment starts from the date of the injured covered employee's receipt of the notification, as required by subdivision (f), of the determination that the employee has a serious chronic condition.

(3) A terminal illness. For purposes of this subdivision, a terminal illness is an incurable or irreversible condition that

has a high probability of causing death within one year or less. Completion of treatment shall be provided for the duration of a terminal illness.

(4) Performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days from the MPN coverage effective date.

(f) If the employer or insurer decides to transfer the covered employee's medical care to the medical provider network, the employer or insurer shall notify the covered employee of the determination regarding the completion of treatment and the decision to transfer medical care into the medical provider network. The notification shall be sent to the covered employee's residence and a copy of the letter shall be sent to the covered employee's primary treating physician. The notification shall be written in English and Spanish and use layperson's terms to the maximum extent possible.

(g) If the injured covered employee disputes the medical determination under this section, the injured covered employee shall request a report from the covered employee's primary treating physician that addresses whether the covered employee falls within any of the conditions set forth in subdivisions (e)(1-4). The treating physician shall provide the report to the covered employee within twenty calendar days of the request. If the treating physician fails to issue the report, then the determination made by the employer or insurer referred to in (f) shall apply.

(h) If the employer or insurer or injured covered employee objects to the medical determination by the treating physician, the dispute regarding the medical determination made by the treating physician concerning the transfer of care shall be resolved pursuant to Labor Code section 4062.

(i) If the treating physician agrees with the employer's or insurer's determination that the injured covered employee's medical condition does not meet the conditions set forth in subdivisions (e)(1) through (e)(4), the transfer of care shall go forward during the dispute resolution process.

(j) If the treating physician does not agree with the employer's or insurer's determination that the injured covered employee's medical condition does not meet the conditions set forth in subdivisions (e)(1) through (e)(4), the transfer of care shall not go forward until the dispute is resolved.

NOTE

Authority cited: Sections 133, 4616(g), and 4062, Labor Code. Reference: Sections 4616 and 4616.2, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including amendment of section, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

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§9767.10. Continuity of Care Policy.

(a) At the request of a covered employee, an insurer or employer that offers a medical provider network shall complete the treatment by a terminated provider as set forth in Labor Code sections 4616.2(d) and (e).

(b) An "acute condition," as referred to in Labor Code section 4616.2(d)(3)(A), shall have a duration of less than ninety days.

(c) "An extended period of time," as referred to in Labor Code section 4616.2(d)(3)(B) with regard to a serious and chronic condition, means a duration of at least ninety days.

(d) The MPN applicant's continuity of care policy shall include a dispute resolution procedure that contains the following requirements:

(1) Following the employer's or insurer's determination of the injured covered employee's medical condition, the employer or insurer shall notify the covered employee of the determination regarding the completion of treatment and whether or not the employee will be required to select a new provider from within the MPN. The notification shall be sent to the covered employee's residence and a copy of the letter shall be sent to the covered employee's primary treating physician. The notification shall be written in English and Spanish and use layperson's terms to the maximum extent possible.

(2) If the terminated provider agrees to continue treating the injured covered employee in accordance with Labor Code section 4616.2 and if the injured covered employee disputes the medical determination, the injured covered employee shall request a report from the covered employee's primary treating physician that addresses whether the covered employee falls within any of the conditions set forth in Labor Code section 4616.2(d)(3); an acute condition; a serious chronic condition; a terminal illness; or a performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date. The treating physician shall provide the report to the covered employee within twenty calendar days of the request. If the treating physician fails to issue the report, then the determination made by the employer or insurer referred to in (d)(1) shall apply.

(3) If the employer or insurer or injured covered employee objects to the medical determination by the treating physician, the dispute regarding the medical determination made by the treating physician concerning the continuity of care shall be resolved pursuant to Labor Code section 4062.

(4) If the treating physician agrees with the employer's or insurer's determination that the injured covered employee's medical condition does not meet the conditions set forth in Labor Code section 4616.2(d)(3), the employee shall choose a new provider from within the MPN during the dispute resolution process.

(5) If the treating physician does not agree with the employer's or insurer's determination that the injured covered employee's medical condition does not meet the conditions set forth in Labor Code section 4616.2(d)(3), the injured covered employee shall continue to treat with the terminated provider until the dispute is resolved.

Note: Authority cited: Sections 133 and 4616(g), Labor Code. Reference: Section 4616.2, Labor Code.

HISTORY 1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3- 1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6- 29-2005 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10- 27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including amendment of section, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

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§9767.11. Economic Profiling Policy

(a) An insurer's or employer's filing of its economic profiling policies and procedures shall include:

(1) An overall description of the profiling methodology, data used to create the profile and risk adjustment;

(2) A description of how economic profiling is used in utilization review;

(3) A description of how economic profiling is used in peer review; and

(4) A description of any incentives and penalties used in the program and in provider retention and termination decisions.

Note: Authority cited: Sections 133 and 4616(g), Labor Code. Reference: Section 4616.1, Labor Code.

HISTORY 1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3- 1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6- 29-2005 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10- 27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

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§9767.12. Employee Notification

(a) An employer or insurer that offers a Medical Provider Network Plan under this article shall notify every covered employee in writing about the use of the Medical Provider Network prior to the implementation of an approved MPN. An implementation notice shall also be provided to a new employee at the time of hire. An implementation notice is not required if the MPN Applicant or insured employer is changing from one MPN to another MPN within 60 days. The MPN implementation notice shall be provided in English and also in Spanish, to Spanish-speaking employees. The written MPN implementation notice to all covered employees shall, at a minimum, include the following information:

(1) That medical treatment for new work injuries will be provided through the Medical Provider Network as of the effective date of coverage unless the employee properly predesignates a physician or medical group prior to injury;

(2) The effective date of coverage under the new MPN;

(3) That existing work injuries may be transferred into the new MPN. The worker should check with the worker's claims adjuster for more information;

(4) That more information about the MPN can be found on the workers' compensation poster or by asking your employer.

(b) The following language may be used for the written MPN implementation notice provided to covered employees: “Unless you predesignate a physician or medical group, your new work injuries arising on or after <INSERT EFFECTIVE DATE OF NEW MPN> will be treated by providers in a new Medical Provider Network, <INSERT NEW MPN NAME>. If you have an existing injury, you may be required to change to a provider in the new MPN. Check with your claims adjuster. You may obtain more information about the MPN from the workers'compensation poster or from your employer.”

(c) The MPN implementation notice may be provided by mail or included on or with an employee's paystub, paycheck or distributed through electronic means, including email, if the employee has regular electronic access to email at work to receive this notice prior to the implementation of the MPN. If the employee cannot receive this notice electronically at work within the required time frame, then the employer shall ensure this information is provided to the employee in writing prior to the implementation of the MPN.

(d) Separate from the MPN implementation notice, a complete written MPN employee notification with the information specified in subdivision (f) of this section about coverage under the MPN shall be provided to covered

employees at the time of injury or when an employee with an existing injury begins treatment under the MPN. This MPN notification shall be provided to employees in English and also in Spanish to Spanish speaking employees. Before MPN coverage is implemented, the complete written MPN employee notification shall also be posted in both English and Spanish in a conspicuous location frequented by employees during the hours of the workday and in close proximity to the workers' compensation posting required under section 9881.

(e) The complete MPN notification may be distributed through electronic means, including email, if the covered employee has regular electronic access to email at work to receive this notice at the time of injury or when the employee is being transferred into the MPN. If the employee cannot receive this notice electronically at work, then the employer shall ensure this information is provided to the employee in writing at the time of injury or when the employee is being transferred into the MPN.

(f) The complete written MPN employee notification shall include the following information:

(1) How to contact the person designated by the employer or insurer to be the MPN Contact for covered employees to answer questions about MPNs and to address MPN problems. The employer or insurer shall provide a toll-free telephone number with access to the MPN Contact if the MPN geographical service area includes more than one area code;

(2) A description of MPN services;

(3) How to review, receive or access the MPN provider directory. An employer or insurer shall ensure covered employees have access to, at minimum, a regional area listing of MPN providers in addition to maintaining and making available its complete provider listing in writing. If an employee requests an electronic listing, it shall be provided electronically on a CD or on a website. If the provider directory is also accessible on a website, the URL address shall be listed with any additional information needed to access the directory online. All provider listings shall be regularly updated, at minimum, on a quarterly basis with the date of the last update provided on the listing given to the employee, to ensure the listing is kept accurate. Each provider listing shall include a phone number and an email address for reporting of provider listing inaccuracies. If a listed provider becomes deceased or is no longer treating workers' compensation patients at the listed address the provider shall be taken off the provider list within 60 days of notice to the MPN network administrator.

(4) How to access initial care and subsequent medical care;

(5) The mileage, time requirements and alternative access standards required under section 9767.5;

(6) How to access treatment if (A) the employee is authorized by the employer to temporarily work or travel for work outside the MPN's geographical service area; (B) a former employee whose employer has ongoing workers' compensation obligations permanently resides outside the MPN geographical service area; and (C) an injured employee decides to temporarily reside outside the MPN geographic service area during recovery;

(7) How to choose a physician within the MPN;

(8) What to do if a covered employee has trouble getting an appointment with a provider within the MPN;

(9) How to change a physician within the MPN;

(10) How to obtain a referral to a specialist within the MPN or outside the MPN, if needed;

(11) How to use the second and third opinion process;

(12) How to request and receive an independent medical review;

(13) A description of the standards for the transfer of care policy and a notification that a copy of the policy shall be

provided to an employee upon request; and

(14) A description of the standards for the continuity of care policy and a notification that a copy of the policy shall be provided to an employee upon request.

(g) At the time of the selection of the physician for a third opinion, the covered employee shall be notified about the Independent Medical Review process. The notification shall be written in English and also in Spanish to Spanish speaking employees.

Note: Authority cited: Sections 133 and 4616, Labor Code. Reference: Sections 4616, 4616.2 and 4616.3, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including amendment of section, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

5. Amendment filed 8-9-2010; operative 10-8-2010 (Register 2010, No. 33).

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§9767.13. Denial of Approval of Application and Reconsideration.

(a) The Administrative Director shall deny approval of a plan if the MPN applicant does not satisfy the requirements of this article and Labor Code section 4616 et seq. and shall state the reasons for disapproval in writing in a Notice of Disapproval, and shall transmit the Notice to the MPN applicant by U.S. Mail.

(b) An MPN applicant denied approval may either:

(1) Submit a new application addressing the deficiencies; or

(2) Request a re-evaluation by the Administrative Director.

(c) Any MPN applicant may request a re-evaluation by submitting with the Division, within 20 days of the issuance of the Notice of Disapproval, a written request for re-evaluation with a detailed statement explaining the basis upon which a re-evaluation is requested. The request for a re-evaluation shall be accompanied by supportive documentary material relevant to the specific allegations raised and shall be verified under penalty of perjury. The MPN application at issue shall not be re-filed; it shall be made part of the administrative record by incorporation by reference.

(d) The Administrative Director shall, within 45 days of the receipt of the request for a re-evaluation, either:

(1) Issue a Decision and Order affirming or modifying the Notice of Disapproval based on a failure to meet the procedural requirements of this section or based on a failure to meet the requirements of Labor Code section 4616 et seq. and this article; or

(2) Issue a Decision and Order revoking the Notice of Disapproval and issue an approval of the MPN.

(e) The Administrative Director may extend the time specified in subdivision (d) within which to act upon the request for a re-evaluation for a period of 30 days and may order a party to submit additional documents or information.

(f) A MPN applicant may appeal the Administrative Director's decision and order regarding the MPN by filing, within twenty (20) days of the issuance of the decision and order, a petition at the district office of the Workers' Compensation Appeals Board closest to the MPN applicant's principal place of business, together with a Declaration of Readiness to Proceed. The petition shall set forth the specific factual and/or legal reason(s) for the appeal. A copy of the petition and of the Declaration of Readiness to Proceed shall be concurrently served on the Administrative Director.

NOTE

Authority cited: Sections 133, 4616(g) and 5300(f), Labor Code. Reference: Section 4616, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including amendment of section heading, section and Note, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

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§9767.14.Suspension or Revocation of Medical Provider Network Plan; Hearing.

(a) The Administrative Director may suspend or revoke approval of a MPN Plan if:

(1) Service under the MPN is not being provided according to the terms of the approved MPN plan.

(2) The MPN fails to meet the requirements of Labor Code section 4616 et seq. and this article.

(3) False or misleading information is knowingly or repeatedly submitted by the MPN or a participating provider or the MPN knowingly or repeatedly fails to report information required by this article.

(4) The MPN knowingly continues to use the services of a provider or medical reviewer whose license, registration, or certification has been suspended or revoked or who is otherwise ineligible to provide treatment to an injured worker under California law.

(b) If one of the circumstances in subdivision (a) exists, the Administrative Director shall notify the MPN applicant in writing of the specific deficiencies alleged. The Administrative Director shall allow the MPN applicant an opportunity to correct the deficiency and/or to respond within ten days. If the Administrative Director determines that the deficiencies have not been cured, he or she shall issue a Notice of Action to the MPN applicant that specifies the time period in which the suspension or revocation will take effect and shall transmit the Notice of Action to the MPN applicant by U.S. Mail.

(c) A MPN applicant may request a re-evaluation of the suspension or revocation by submitting to the Administrative Director, within 20 days of the issuance of the Notice of Action, a written notice of the request for a re-evaluation with a detailed statement explaining the basis upon which a re-evaluation is requested. The request for a re-evaluation shall be accompanied by supportive documentary material relevant to the specific allegations raised and shall be verified under penalty of perjury. The MPN application at issue shall not be re-filed; it shall be made part of the administrative record and incorporated by reference.

(d) The Administrative Director shall, within 45 days of the receipt of the request for a re-evaluation, either:

(1) Issue a Decision and Order affirming or modifying the Notice of Action based on a failure to meet the procedural requirements of this section or based on a failure to meet the requirements of Labor Code section 4616 et seq. and this article;

(2) Issue a Decision and Order revoking the Notice of Action;

(e) The Administrative Director may extend the time specified in subdivision (d) within which to act upon the request for a re-evaluation for a period of 30 days and may order a party to submit additional documents or information.

(f) A MPN applicant may appeal the Administrative Director's decision and order regarding the MPN by filing, within twenty (20) days of the issuance of the decision and order, a petition at the district office of the Workers' Compensation Appeals Board closest to the MPN applicant's principal place of business, together with a Declaration of Readiness to Proceed. The petition shall set forth the specific factual and/or legal reason(s) for the appeal. A copy of the petition and of the Declaration of Readiness to Proceed shall be concurrently served on the Administrative Director.

NOTE

Authority cited: Sections 133, 4616(g) and 5300(f), Labor Code. Reference: Section 4616, Labor Code.

HISTORY

1. New section filed 11-1-2004 as an emergency; operative 11-1-2004 (Register 2004, No. 45). A Certificate of Compliance must be transmitted to OAL by 3-1-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2-28-2005 as an emergency; operative 3-1-2005 (Register 2005, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-29-2005 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 6-20-2005 as an emergency; operative 6-29-2005 (Register 2005, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-27-2005 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-20-2005 order, including amendment of section, transmitted to OAL 7-29-2005 and filed 9-9-2005 (Register 2005, No. 36).

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§9767.15. Compliance with Permanent MPN Regulations.

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a. This section applies to MPNs that were approved by the Administrative Director pursuant to the emergency Medical Provider Network regulations effective November 1, 2004

b. Employers or insurers whose MPNs were approved pursuant to the emergency Medical Provider Network regulations are not required to submit a Notice of MPN Plan Modification to comply with the new or revised sections of the permanent regulations, including:

1. Section 9767.3(d)(8)(C) or Section 9767.3(d)(16) regarding the contractual agreements contained in the Application for a Medical Provider Network Plan provisions.

2. Sections 9767.5(e)(1), (e)(2), (e)(3), (e)(4), 9767.5(h) and 9767.5(i) of the Access Standards provisions.

3. Section 9767.9(g) provision providing a timeline for the treating physician's report and what happens if the treating physician fails to issue a timely report contained in the Transfer of Ongoing Care into the MPN provisions.

4. Section 9767.10(b)(c) and (d) of the Continuity of Care provisions.

5. Section 9767.12(a), (a)(1), (a)(2), (a)(3), (a)(4) and (a)(5) of the Employee Notification provisions.

c. At the time an employer or insurer with an approved MPN pursuant to the emergency Medical Provider Network regulations submits a Notice of MPN Plan Modification, the employer or insurer shall be required to verify compliance with the sections of the MPN permanent regulations listed in subdivision (b) above.

NOTE

Authority cited: Sections 133, 4616(g) and 5300(f), Labor Code. Reference: Sections 4609, 4616, 4616.2 and 4616.3, Labor Code.

HISTORY

1. New section filed 9-9-2005; operative 9-9-2005 (Register 2005, No. 36).

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§9767.16. Notice to Employee Upon Termination, Cessation of Use, or Change of Medical Provider Network

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(a) The Medical Provider Network Applicant is responsible for ensuring that each injured covered employee is informed in writing of the MPN policies under which he or she is covered and when the injured employee is no longer covered by the Applicant's MPN. The MPN Applicant shall ensure each injured covered employee is given written notice of the date of termination or cessation of use of its MPN. The written notice shall be provided to injured covered employees prior to the effective date of termination or cessation of use of the Applicant's MPN. The notices required by this section shall be provided in English and also in Spanish to Spanish speaking employees.

(1) The MPN Applicant whose MPN is being terminated or will cease to be used shall ensure that every injured covered employee is provided the following information prior to the termination or cessation of use of its MPN by a MPN Applicant or an insured employer:

(A) The effective date of termination or cessation of use of the Applicant's MPN.

(B) Whether the MPN will still be used for injuries arising before the date MPN coverage ends.

(C) The address, telephone number, email address and an MPN website, (optional), of the MPN Contact who can address MPN questions.

(D) For periods when an employee is not covered by a MPN, an employee may choice a physician 30 days after the date the employee notified the employer of his or her injury.

(E)(2) The following language may be provided in writing to injured covered employees to give the required notice of termination or cessation of use of a MPN: “The <Insert MPN Name> Medical Provider Network (MPN) will no longer be used for injuries arising after <Insert Date of MPN Termination or Cessation of Use>. You will/will not <Select Whichever is Appropriate> continue to use this MPN to obtain care for work injuries occurring before this date. For new injuries that occur when you are not covered by a MPN, you have the right to choose your physician 30 days after you notify your employer of your injury. You may obtain more information at <Insert MPN Contact Phone Number, Address, Email Address, and MPN Website (optional).”

(3) The notice of MPN termination or cessation of use may be provided by mail or included on or with an employee's paystub, paycheck or distributed through electronic means, including email, if the employee has regular electronic access to email at work to receive this notice prior to the end of MPN coverage. If the employee cannot receive this notice electronically at work within the required time frame, then the employer shall ensure this information is provided to the employee in writing prior to the end of MPN coverage.

(4) Any pending Independent Medical Review will end with the employee's coverage under the MPN.

(b) If a MPN Applicant or insured employer is changing MPN coverage to a different MPN, the MPN Applicant that is providing the new MPN coverage shall ensure that every injured covered employee is provided written notice of the following information prior to the effective date of coverage under that Applicant's MPN:

(1) That medical treatment for new work injuries will be provided through the Medical Provider Network as of the effective date of coverage unless the employee properly predesignates a physician or medical group prior to injury;

(2) The effective date of coverage under the new MPN;

(3) That existing work injuries may be covered under the prior MPN or may be transferred into the new MPN. The worker should check with the worker's claims adjuster for more information;

(4) That for periods when the worker is not covered by a MPN, an employee may choose a physician 30 days after the date the employee notified the employer of his or her injury;

(5) The MPN Contact's telephone number, address, email address, and an MPN website (optional), for the worker to obtain more information about using the MPN.

(c) The following language may be provided in writing to injured covered employees to give the required notice of the change of MPN coverage: “Unless you predesignate a physician or medical group prior to injury, your new work injuries arising on or after <INSERT EFFECTIVE DATE OF NEW MPN> will be treated by providers in a new Medical Provider Network, <INSERT NEW MPN NAME>. If you have an existing injury, you may be required to continue care under your prior MPN or you may be required to change to a provider in the new MPN. Check with your claims adjuster. For periods when you are not covered under a MPN, you may choose a physician 30 days after you've notified your employer of your injury. You may obtain more information at <INSERT MPN CONTACT, PHONE NUMBR, ADDRESS, EMAIL ADDRESS, AND AN MPN WEBSITE (optional).”

(d) Notice of termination or cessation of use of a MPN may be combined with the notice of a change to new MPN coverage if the combined notice meets all the MPN regulatory requirements for termination or cessation of use of a MPN and for change of a MPN.

(e) Notices required by this section shall be provided in English and also in Spanish to Spanish speaking employees.

(f) The notice of a change of MPN coverage may be provided by mail or included on or with an employee's paystub, paycheck or distributed through electronic means, including email, if the covered employee has regular electronic access to email at work to receive this notice prior to the beginning of new MPN coverage. If the employee cannot receive this notice electronically at work within the required time frame, then the employer shall ensure this information is provided to the employee in writing prior to the beginning of new MPN coverage.

(g) If a change in MPN coverage results in modifications to an MPN's plan application or results in the filing of a new MPN application, the MPN modification or new application filing shall be submitted to DWC pursuant to section 9767.8 or 9767.3, whichever is applicable. Distribution to injured covered employees of the notice of a change of MPNs shall occur after DWC's approval of a MPN modification or new MPN.

Note: Authority cited: Sections 59, 124, 133, 138.3, 138.4, 4616 and 5307.3, Labor Code. Reference: Sections 3550 and 4616.2, Labor Code.

HISTORY

1. New section filed 12-11-2007; operative 4-9-2008 (Register 2007, No. 50).

2. Amendment of section heading, section and Note filed 8-9-2010; operative 10-8-2010 (Register 2010, No. 33).

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Article 3.6. Certification Standards for Health Care Organizations

New query

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§9768.1. Definitions

(a) As used in this article, the following definitions apply:

(1) “American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines” (“ACOEM”) means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, 2nd Edition (2004), published by OEM Press. The Administrative Director incorporates ACOEM by reference. A copy may be obtained from OEM Press, 8 West Street, Beverly Farms, Massachusetts 01915 (www.oempress.com).

(2) “Appropriate specialty” means a medical specialty in an area or areas appropriate to the condition or treatment under review.

(3) “Independent Medical Reviewer” (“IMR”) means the physician who is randomly selected pursuant to subdivision (b) of Labor Code section 4616.4.

(4) “In-person examination” means an examination of an injured employee by a physician which involves more than a review of records, and may include a physical examination, discussing the employee's medical condition with the employee, taking a history and performing an examination.

(5) “Material familial affiliation” means a relationship in which one of the persons or entities listed in section 9768.2 is the parent, child, grandparent, grandchild, sibling, uncle, aunt, nephew, niece, spouse, or cohabitant of the Independent Medical Reviewer.

(6) “Material financial affiliation” means a financial interest (owns a legal or equitable interest of more than 1% interest in the party, or a fair market value in excess of $2000, or relationship of director, advisor, or active participant) in any person or entity listed in section 9768.2. It also means any gift or income of more than $300 in the preceding year except for income for services as a second opinion physician, third opinion physician, treating physician, Agreed Medical Evaluator, Qualified Medical Evaluator, or Independent Medical Reviewer.

(7) “Material professional affiliation” means any relationship in which the Independent Medical Reviewer shares office space with, or works in the same office of, any person or entity listed in section 9768.2.

(8) “Medical emergency” means a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

(9) “Medical Provider Network Contact” (“MPN Contact”) means the individual(s) designated by the MPN Applicant in the employee notification who is responsible for answering employees' questions about the Medical Provider Network and is responsible for assisting the employee in arranging for an Independent Medical Review.

(10) “Panel” means the contracted providers in a specific specialty.

(11) “Relevant medical records” means all information that was considered in relation to the disputed treatment or diagnostic service, including: (A) a copy of all correspondence from, and received by, any treating physician who provided a treatment or diagnostic service to the injured employee in connection with the injury; (B) a complete and legible copy of all medical records and other information used by the physicians in making a decision regarding the disputed treatment or diagnostic service; (C) the treating physician's report with the disputed treatment or diagnosis; and (D) the second and third opinion physicians' reports.

(12) “Residence” means the covered employee's primary residence.

NOTE

Authority cited: Sections 133 and 4616, Labor Code. Reference: Section 4616.4, Labor Code.

HISTORY

1. New article 3.6 (sections 9768.1-9768.17) and section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order, including amendment of section, transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9768.2 Conflicts of Interest

(a) The IMR shall not have any material, professional, familial, or financial affiliation with any of the following:

(1) The injured employee's employer or employer's workers' compensation insurer;

(2) Any officer, director, management employee, or attorney of the injured employee's medical provider network, employer or employer's workers' compensation insurer;

(3) Any treating health care provider proposing the service or treatment;

(4) The institution at which the service or treatment would be provided, if known;

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed for the injured employee whose treatment is under review; or

(6) The injured employee, the injured employee's immediate family, or the injured employee's attorney.

(b) The IMR shall not have a contractual agreement to provide physician services for the injured employee's MPN if the IMR is within a 35 mile radius of the treating physician.

(c) The IMR shall not have previously treated or examined the injured employee.

NOTE

Authority cited: Sections 133 and 4616, Labor Code. Reference: Section 4616.4, Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9768.3 Qualifications of Independent Medical Reviewers

(a) To qualify to be on the Administrative Director's list of Independent Medical Reviewers, a physician shall file a Physician Contract Application pursuant to section 9768.5 that demonstrates to the satisfaction of the Administrative Director that the physician:

(1) Is board certified. For physicians, the Administrative Director shall recognize only specialty boards recognized by the appropriate California licensing board.

(2) Has an unrestricted license as a physician in California under the appropriate licensing Board;

(3) Is not currently under accusation by any governmental licensing agency for a quality of care violation, fraud related to medical practice, or felony conviction or conviction of a crime related to the conduct of his or her practice of medicine;

(4) Has not been terminated or had discipline imposed by the Industrial Medical Council or Administrative Director in relation to the physician's role as a Qualified Medical Evaluator; is not currently under accusation by the Industrial Medical Council or Administrative Director; has not been denied renewal of Qualified Medical Evaluator status, except for non-completion of continuing education or for non-payment of fees; has neither resigned nor failed to renew Qualified Medical Evaluator status while under accusation or probation by the Industrial Medical Council or Administrative Director or after notification that reappointment as a Qualified Medical Evaluator may or would be denied for reasons other than non-completion of continuing education or non-payment of fees; and has not filed any applications or forms with the Industrial Medical Council or Administrative Director which contained any untrue material statements;

(5) Has not been convicted of a felony crime or a crime related to the conduct of his or her practice of medicine; and

(6) Has no history of disciplinary action or sanction, including but not limited to, loss of staff privileges or participation restrictions taken or pending by any hospital, government or regulatory body.

NOTE

Authority cited: Sections 133 and 4616, Labor Code. Reference: Section 4616.4, Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on

the following day.

2. Certificate of Compliance as to 12-31-2004 order, including amendment of subsections (a) and (a)(3), transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9768.4. IMR Contract Application Procedures.

(a) A physician seeking to serve as an Independent Medical Reviewer shall:

(1) Apply to the Administrative Director on the Physician Contract Application set forth in section 9768.5.

(2) Furnish a certified copy of his or her board certification, a copy of his or her current license to practice medicine, and submit other documentation of his or her qualifications as the Administrative Director may require.

(3) Designate specialties based on each of his or her board certifications.

(4) Designate the address(es) of the physician's office with necessary medical equipment where in-person examinations will be held.

(5) Agree to see any injured worker assigned to him or her within 30 days unless there is a conflict of interest as defined in section 9768.2.

(6) During the application process and after being notified by the Administrative Director that the contract application has been accepted, the physician shall keep the Administrative Director informed of any change of address, telephone, email address or fax number, and of any disciplinary action taken by a licensing board.

(b) The contract application, completed by the physician, and any supporting documentation included with the contract application, shall be filed at the Administrative Director's office listed on the form. The contract application submitted by the physician may be rejected if it is incomplete, contains false information or does not contain the required supporting documentation listed in this section.

(c) The Administrative Director shall maintain a list of physicians who have applied, and whom the Administrative Director has contracted with to conduct Independent Medical Reviews under Labor Code section 4616.4.

(d) The IMR contract term is two years. A physician may apply to serve for subsequent two year terms by following the procedure set forth in subdivision (a).

NOTE

Authority cited: Sections 133 and 4616, Labor Code. Reference: Section 4616.4, Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order, including amendment of subsections (a) and (c), transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9768.5. Physician Contract Application Form

Physician application contract DWC form 9768.5 (pdf)

Note to physicians: please use three letter specialty code when completing block 3 of application form)
SPECIALTY CODES
MAI Allergy and Immunology
MAA Anesthesiology
MRS Colon & Rectal Surgery
MDE Dermatology
MEM Emergency Medicine
MFP Family Practice
MPM General Preventive Medicine
MOSU Hand - Orthopaedic Surgery, Plastic Surgery, General Surgery
MMM Internal Medicine
MMV Internal Medicine - Cardiovascular Disease
MME Internal Medicine - Endocrinology Diabetes and Metabolism
MMG Internal Medicine - Gastroenterology
MMH Internal Medicine - Hematology
MMI Internal Medicine - Infectious Disease
MMO Internal Medicine - Medical Oncology
MMN Internal Medicine - Nephrology
MMP Internal Medicine - Pulmonary Disease
MMR Internal Medicine - Rheumatology
MPN Neurology
MNS Neurological Surgery
MNM Nuclear Medicine
MOG Obstetrics and Gynecology
MPO Occupational Medicine
MOP Opthalmology
MOSG Orthopaedic Surgery (General)
MOSS Orthopaedic - Shoulder
MOSK Orthopaedic - Knee
MOSB Orthopaedic - Spine
MOSF Orthopaedic - Foot and ankle

MTO Otolaryngology
MAP Pain Management - Psychiatry and Neurology, Physical Medicine and Rehabilitation, Anesthesiology
MHA Pathology
MEP Pediatrics
MPR Physical Medicine & Rehabilitation
MPS Plastic Surgery
MPD Psychiatry
MSY Surgery
MSG Surgery - General Vascular
MTS Thoracic Surgery
MTO Toxicology - Preventive Medicine, Pediatrics, Emergency
MUU Urology
MRD Radiology
POD Podiatry
DWC Form 9768.5 11/2006

Note: Authority cited: Sections 133 and 4616, Labor Code. Reference: Section 4616.4, Labor Code.Authority cited: Sections 133 and 4616, Labor Code. Reference: Section 4616.4, Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order, including amendment of section, transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

3. Change without regulatory effect amending form filed 10-18-2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No.42).

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§9768.6. Administrative Director's Action on Contract Application Submitted by Physician

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(a) After reviewing a completed contract application submitted by a physician, if the Administrative Director finds that the physician meets the qualifications, he/she shall accept the contract application made by the physician to be an Independent Medical Reviewer by executing the IMR contract, notify the physician by mail, and add the physician's name to the list of Independent Medical Reviewers. The contract term shall be for a two-year term beginning with the date of acceptance by the Administrative Director.

(b) If the Administrative Director determines that a physician does not meet the qualifications, he/she shall notify the physician by mail that the physician's contract application is not accepted and the reason for the rejection.

(c) A physician whose contract application has not been accepted may reapply.

(d) If the Administrative Director denies a physician's contract application following at least two subsequent submissions, the physician may seek further review of the Administrative Director's decision by filing an appeal with the Workers' Compensation Appeals Board, and serving a copy on the Administrative Director, within twenty days after receipt of the denial.

NOTE

Authority cited: Sections 133 and 4616, Labor Code. Reference: Sections 4616.4 and 5300(f), Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order, including amendment of subsection (a), transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9768.7. IMR Request to Be Placed on Voluntary Inactive Status

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A physician may request to be placed on the inactive list during the IMR contract term. The physician shall submit the request to the Administrative Director and specify the time period that he or she is requesting to be on voluntary inactive status. The two-year contract term is not extended due to a physician's request to be placed on voluntary inactive status.

NOTE

Authority cited: Sections 133 and 4616, Labor Code. Reference: Section 4616.4, Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9768.8. Removal of Physicians from Independent Medical Reviewer List

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(a) The Administrative Director may cancel the IMR contract and remove a physician from the Independent Medical Reviewer list if the Administrative Director determines based upon the Administrative Director's monitoring of reports:

(1) That the physician, having been notified by the Administrative Director of the physician's selection to render an Independent Medical Review, has not issued the Independent Medical Review report in a case within the time limits prescribed in these regulations on more than one occasion; or

(2) That the physician has not met the reporting requirements on more than one occasion; or

(3) That the physician has at any time failed to disclose to the Administrative Director that the physician had a conflict of interest pursuant to section 9768.2; or

(4) That the physician has failed to schedule appointments within the time frame required by these regulations on more than one occasion; or

(5) That the physician has failed to maintain the confidentiality of medical records and the review materials consistent with the applicable state and federal law.

(b) The Administrative Director shall cancel the IMR contract and remove a physician from the Independent Medical Reviewer list if the Administrative Director determines:

(1) That the physician no longer meets the qualifications to be on the list; or

(2) That the physician's contract application to be on the list contained material statements which were not true.

(c) The Administrative Director shall place a physician on an inactive list for up to the end of the two year contract term whenever the Administrative Director determines that the appropriate licensing Board from whom the physician is licensed has filed an accusation for a quality of care violation, fraud related to medical practice, or conviction of a felony crime or a crime related to the conduct of his or her practice of medicine against the physician or taken other action restricting the physician's medical license. If the accusation or action is later withdrawn, dismissed or determined to be without merit during the two year contract term, the physician shall advise the Administrative Director who will then remove the physician's name from the inactive list. If the accusation or action is withdrawn, dismissed or determined to be without merit after the expiration of the two year contract term, the physician may reapply to serve as an Independent Medical Reviewer pursuant to section 9768.4.

(d) Upon removal of a physician from the Independent Medical Reviewer list or placement on the inactive list, the

Administrative Director shall advise the physician by mail of the removal or placement on the inactive list, the Administrative Director's reasons for such action, and the right to request a hearing on the removal from the IMR list or placement on the inactive list.

(e) A physician who has been mailed a notice of removal from the list or placement on the inactive list, may, within 30 calendar days of the mailing of the notice, request a hearing by filing a written request for hearing with the Administrative Director. If a written request for hearing is not received by the Administrative Director within 30 calendar days of the mailing of the notice, the physician shall be deemed to have waived any appeal or request for hearing.

(f) Upon receipt of a written request for hearing, the Administrative Director shall prepare an accusation and serve the applicant physician with the accusation, as provided in Government Code section 11503.

(g) Hearings shall be held by the Administrative Director or his or her designee under the procedures of Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code (commencing with section 11500) and the regulations of the Office of Administrative Hearings (Title 1, California Code of Regulations, section 1000 et seq.).

(h) Failure to timely file a notice of defense or failure to appear at a noticed hearing or conference shall constitute a waiver of a right to a hearing.

(i) A physician who has been removed from the list may petition for reinstatement after one year has elapsed since the effective date of the Administrative Director's decision on the physician's removal. The provisions of Government Code section 11522 shall apply to such petition.

NOTE

Authority cited: Sections 133 and 4616, Labor Code; and Section 11400.20, Government Code. Reference: Section 4616.4, Labor Code; and Sections 11415.10, 11503 and 11522, Government Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order, including amendment of section, transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9768.9. Procedure for Requesting an Independent Medical Review

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(a) If a covered employee disputes the diagnostic service, diagnosis, or medical treatment prescribed by the second opinion physician, the injured employee may seek the opinion of a third physician in the MPN. The covered employee and the employer or insurer shall comply with the requirements of section 9767.7(d). Additionally, at the time of the selection of the physician for a third opinion, the MPN Contact shall notify the covered employee about the Independent Medical Review process and provide the covered employee with an “Independent Medical Review Application” form set forth in section 9768.10. The MPN Contact shall fill out the “MPN Contact Section” of the form and list the specialty of the treating physician and an alternative specialty, if any, that is different from the specialty of the treating physician.

(b) If a covered employee disputes either the diagnostic service, diagnosis or medical treatment prescribed by the third opinion physician, the covered employee may request an Independent Medical Review by filing the completed Independent Medical Review Application form with the Administrative Director. The covered employee shall complete the “employee section” of the form, indicate on the form whether he or she requests an in-person examination or record review, and may list an alternative specialty, if any, that is different from the specialty of the treating physician.

(c) The Administrative Director shall select an IMR with an appropriate specialty within ten business days of receiving the Independent Medical Review Application form. The Administrative Director's selection of the IMR shall be based on the specialty of the treating physician, the alternative specialties listed by the covered employee and the MPN Contact, and the information submitted with the Independent Medical Review Application.

(d) If the covered employee requests an in-person examination, the Administrative Director shall randomly select a physician from the panel of available Independent Medical Reviewers, with an appropriate specialty, who has an office located within thirty miles of the employee's residence address, to be the Independent Medical Reviewer. If there is only one physician with an appropriate specialty within thirty miles of the employee's residence address, that physician shall be selected to be the Independent Medical Reviewer. If there are no physicians with an appropriate specialty who have offices located within thirty miles of the employee's residence address, the Administrative Director shall search in increasing five mile increments, until one physician is located. If there are no available physicians with this appropriate specialty, the Administrative Director may choose another specialty based on the information submitted.

(e) If the covered employee requests a record review, then the Administrative Director shall randomly select a physician with an appropriate specialty from the panel of available Independent Medical Reviewers to be the IMR. If there are no physicians with an appropriate specialty, the Administrative Director may choose another specialty based on the information submitted.

(f) The Administrative Director shall send written notification of the name and contact information of the IMR to the

covered employee, the employee's attorney, if any, the MPN Contact and the IMR. The Administrative Director shall send a copy of the completed Independent Medical Review Application to the IMR.

(g) The covered employee, MPN Contact, or the selected IMR can object within 10 calendar days of receipt of the name of the IMR to the selection if there is a conflict of interest as defined by section 9768.2. If the IMR determines that he or she does not practice the appropriate specialty, the IMR shall withdraw within 10 calendar days of receipt of the notification of selection. If this conflict is verified or the IMR withdraws, the Administrative Director shall select another IMR from the same specialty. If there are no available physicians with the same specialty, the Administrative Director may select an IMR with another specialty based on the information submitted and in accordance with the procedure set forth in subdivision (d) for an in-person examination and subdivision (e) for a record review.

(h) If the covered employee requests an in-person exam, within 60 calendar days of receiving the name of the IMR, the covered employee shall contact the IMR to arrange an appointment. If the covered employee fails to contact the IMR for an appointment within 60 calendar days of receiving the name of the IMR, then the employee shall be deemed to have waived the IMR process with regard to this disputed diagnosis or treatment of this treating physician. The IMR shall schedule an appointment with the covered employee within 30 calendar days of the request for an appointment, unless all parties agree to a later date. The IMR shall notify the MPN Contact of the appointment date.

(i) The covered employee shall provide written notice to the Administrative Director and the MPN Contact if the covered employee decides to withdraw the request for an Independent Medical Reviewer.

(j) During this process, the employee shall remain within the MPN for treatment pursuant to section 9767.6.

NOTE

Authority cited: Sections 133 and 4616, Labor Code. Reference: Sections 4616.3 and 4616.4, Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order, including amendment of section, transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9768.10. Application for Independent Medical Review (Form).

View Graphic

Note: Authority cited: Sections 133 and 4616, Labor Code. Reference: Sections 4616.3 and 4616.4, Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order, including amendment of section heading and section, transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

3. Change without regulatory effect amending form filed 10-18-2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No.42).

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§9768.11. In-Person Examination or Record Review IMR Procedure

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(a) The MPN Contact shall send all relevant medical records to the IMR. The MPN Contact shall also send a copy of the documents to the covered employee. The employee may furnish any relevant medical records or additional materials to the Independent Medical Reviewer, with a copy to the MPN Contact. If an in-person examination is requested and if a special form of transportation is required because of the employee's medical condition, it is the obligation of the MPN Contact to arrange for it. The MPN Contact shall furnish transportation and arrange for an interpreter, if necessary, in advance of the in-person examination. All reasonable expenses of transportation shall be incurred by the insurer or employer pursuant to Labor Code section 4600. Except for the in-person examination itself, the Independent Medical Reviewer shall have no ex parte contact with any party. Except for matters dealing with scheduling appointments, scheduling medical tests and obtaining medical records, all communications between the Independent Medical Reviewer and any party shall be in writing, with copies served on all parties.

(b) If the IMR requires further tests, the IMR shall notify the MPN Contact within one working day of the appointment. All tests shall be consistent with the medical treatment utilization schedule adopted pursuant to Labor Code section 5307.27 or, prior to the adoption of this schedule, the ACOEM guidelines, and for all injuries not covered by the medical treatment utilization schedule or the ACOEM guidelines, in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based.

(c) The IMR may order any diagnostic tests necessary to make his or her determination regarding medical treatment or diagnostic services for the injury or illness but shall not request the employee to submit to an unnecessary exam or procedure. If a test duplicates a test already given, the IMR shall provide justification for the duplicative test in his or her report.

(d) If the employee fails to attend an examination with the IMR and fails to reschedule the appointment within five business days of the missed appointment, the IMR shall perform a review of the record and make a determination based on those records.

(e) The IMR shall serve the report on the Administrative Director, the MPN Contact, the employee and the employee's attorney, if any, within 20 days after the in-person examination or completion of the record review.

(f) If the disputed health care service has not been provided and the IMR certifies in writing that an imminent and serious threat to the health of the injured employee exists, including, but not limited to, the potential loss of life, limb, or bodily function, or the immediate and serious deterioration of the injured employee, the report shall be expedited and rendered within three business days of the in-person examination by the IMR.

(g) Subject to approval by the Administrative Director, reviews not covered under subdivision (f) may be extended for up to three business days in extraordinary circumstances or for good cause.

(h) Extensions for good cause shall be granted for:

(1) Medical emergencies of the IMR or the IMR's family;

(2) Death in the IMR's family; or

(3) Natural disasters or other community catastrophes that interrupt the operation of the IMR's office operations.

(i) Utilizing the medical treatment utilization schedule established pursuant to Labor Code section 5307.27 or, prior to the adoption of this schedule, the ACOEM guidelines, and taking into account any reports and information provided, the IMR shall determine whether the disputed health care service is consistent with the recommended standards. For injuries not covered by the medical treatment utilization schedule or by the ACOEM guidelines, the treatment rendered shall be in accordance with other evidence-based medical treatment guidelines which are generally recognized by the national medical community and scientifically based.

(j) The IMR shall not treat or offer to provide medical treatment for that injury or illness for which he or she has done an Independent Medical Review evaluation for the employee unless a medical emergency arises during the in-person examination.

(k) Neither the employee nor the employer nor the insurer shall have any liability for payment for the Independent Medical Review which was not completed within the required timeframes unless the employee and the employer each waive the right to a new Independent Medical Review and elect to accept the original evaluation.

Note: Authority cited: Sections 133 and 4616, Labor Code. Reference: Sections 4616.4 and 5307.27, Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order, including amendment of subsections (a), (e), (j) and (k), transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9768.12. Contents of Independent Medical Review Reports

(a) Reports of Independent Medical Reviewers shall include:

(1) The date of the in-person examination or record review;

(2) The patient's complaint(s);

(3) A listing of all information received from the parties reviewed in preparation of the report or relied upon for the formulation of the physician's opinion;

(4) The patient's medical history relevant to the diagnostic services, diagnosis or medical treatment;

(5) Findings on record review or in-person examination;

(6) The IMR's diagnosis;

(7) The physician's opinion whether or not the proposed treatment or diagnostic services are appropriate and indicated. If the proposed treatment or diagnostic services are not appropriate or indicated, any alternative diagnosis or treatment recommendation consistent with the medical treatment utilization schedule shall be included;

(8) An analysis and determination whether the disputed health care service is consistent with the medical treatment utilization schedule established pursuant to Labor Code section 5307.27 or, prior to the adoption of this schedule, the ACOEM guidelines. For injuries not covered by the medical treatment utilization schedule or by the ACOEM guidelines, an analysis and determination whether the treatment rendered is in accordance with other evidence-based medical treatment guidelines which are generally recognized by the national medical community and scientifically based; and

(9) The signature of the physician.

(b) The report shall be in writing and use layperson's terms to the maximum extent possible.

(c) An Independent Medical Reviewer shall serve with each report the following executed declaration made under penalty of perjury:

“I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3.

_____
Date

_____”
Signature

NOTE

Authority cited: Sections 133 and 4616, Labor Code. Reference: Sections 139.3, 4616.4 and 5307.27, Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order, including amendment of subsections (a) and (c), transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9768.13. Destruction of Records by the Administrative Director.

The Administrative Director may destroy any forms or documents submitted to the Administrative Director as part of the IMR process two years after the date of receipt.

NOTE

Authority cited: Sections 133 and 4616, Labor Code. Reference: Section 4616.4, Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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New query

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§9768.14. Retention of Records by Independent Medical Reviewer

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Each Independent Medical Reviewer shall retain all comprehensive medical reports completed by the Independent Medical Reviewer for a period of five years from the date of the IMR report.

NOTE

Authority cited: Sections 133 and 4616, Labor Code. Reference: Section 4616.4, Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order, including amendment of section, transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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New query

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§9768.15. Charges for Independent Medical Reviewers

(a) Payment for the services of the Independent Medical Reviewers shall be made by the employer or insurer.

(b) The fee shall be based on the Official Medical Fee Schedule using confirmatory consultation codes (99271 through 99275 for in-person examinations or 99271 through 99273 for evaluations not requiring an in-person examination), 99080 for reports, and 99358 for record reviews, and any other appropriate codes or modifiers.

(c) An IMR shall not accept any additional compensation from any source for his or her services as an IMR except for services provided to treat a medical emergency that arose during an in-person examination pursuant to section 9768.11(j).

NOTE

Authority cited: Sections 133 and 4616, Labor Code. Reference: Section 4616.4, Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order, including amendment of subsections (a) and (b), transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9768.16. Adoption of Decision.

(a) The Administrative Director shall immediately adopt the determination of the Independent Medical Reviewer and issue a written decision within 5 business days of receipt of the report.

(b) The parties may appeal the Administrative Director's written decision by filing a petition with the Workers' Compensation Appeals Board and serving a copy on the Administrative Director, within twenty days after receipt of the decision.

NOTE

Authority cited: Sections 133 and 4616, Labor Code. Reference: Sections 4616.4 and 5300(f), Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order, including amendment of subsection (a), transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9768.17. Treatment Outside the Medical Provider Network

(a) If the IMR agrees with the diagnosis, diagnostic service or medical treatment prescribed by the treating physician, the covered employee shall continue to receive medical treatment from physicians within the MPN.

(b) If the IMR does not agree with the disputed diagnosis, diagnostic service or medical treatment prescribed by the treating physician, the covered employee shall seek medical treatment with a physician of his or her choice either within or outside the MPN. If the employee chooses to receive medical treatment with a physician outside the MPN, the treatment is limited to the treatment recommended by the IMR or the diagnostic service recommended by the IMR.

(c) The medical treatment shall be consistent with the medical treatment utilization schedule established pursuant to Labor Code section 5307.27 or, prior to the adoption of this schedule, the ACOEM guidelines. For injuries not covered by the medical treatment utilization schedule or by the ACOEM guidelines, the treatment rendered shall be in accordance with other evidence-based medical treatment guidelines which are generally recognized by the national medical community and scientifically based.

(d) The employer or insurer shall be liable for the cost of any approved medical treatment in accordance with Labor Code section 5307.1 or 5307.11.

NOTE

Authority cited: Sections 133 and 4616, Labor Code. Reference: Sections 4616.4, 5307.1, 5307.11 and 5307.27, Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12-31-2004 order, including amendment of Note, transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9770. Definitions.

(a) "Administrative Director" means the administrative director of the Division of Workers' Compensation.

(b) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(c) "Division" means the Division of Workers' Compensation.

(d) "Employer" means an employer as defined in Section 3300 of the Labor Code.

(e) "HCO Enrollee" means a person who is eligible to receive services from an HCO.

(f) "Health care organization" ("HCO") means any entity certified as a health care organization by the administrative director pursuant to Section 4600.5 of the Labor Code and this article.

(g) "International Classification of Diseases--9th Revision (ICD-9) code" means the 4 or 5 digit number which identifies the illness, injury, disease, cause of death, or other morbid state of an enrollee that corresponds to the numeric classifications and descriptions listed in International Classification of Diseases. Clinical Modification. 9th Revision (ICD-9CM) US Department of Health and Human Services, Health Care Financing Administration. Washington DC: Superintendent of Documents, and updated successor revised manuals.

(h) "Material": A factor is "material" with respect to a matter if it is one to which a reasonable person would attach importance in determining the action to be taken upon the matter.

(i) "Participating provider" means a provider who is employed by or under contract with an HCO for purposes of providing occupational medical or health services or services required by this article.

(j) "Patient" means an HCO enrollee who is currently obtaining treatment or services for a work-related injury or illness.

(k) "Primary treating physician" means the treating physician primarily responsible for managing the care of the injured worker in accordance with Section 9785.5.

(l) "Professionally recognized standards of care" means health care practice encompassing the learning, skill and clinical judgment ordinarily possessed and and used by a provider of good standing in similar circumstances.

(m) "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(n) "Revocation" means the termination of a health care organization's certification to provide services pursuant to Section 4600.5 of the Labor Code and this article.

(o) "Standard Industrial Classification code" means the 4 digit number which identifies the primary type of economic activity which the employer is engaged in that corresponds to the numeric classifications and descriptions listed in The Standard Industrial Classification Manual 1987, Office of Management and Budget, Washington DC: Superintendent of Documents, US Government Printing Office, 1989, and updated successor revised manuals.

(p) "Suspension" means the health care organization's authority to enter into new, renewed, or amended contracts with claims administrators has been suspended by the administrative director for a specific period of time.

(q) "Utilization review" or "Utilization Management" is the system used to manage, assess, improve, or review patient care and decision-making through case by case assessments of the medical reasonableness or medical necessity of the frequency, duration, level and appropriateness of medical care and services, based upon professionally recognized standards of care. Utilization review may include, but is not limited to, prospective, concurrent, and retrospective review of a request for authorization of medical treatment.

NOTE: Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code. Reference: Sections 3300, 4061.5, 4600.5, 5400, 5401 and 5402, Labor Code.

HISTORY

1. New article 4 and section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53). For prior history, see Register 84, No. 35.

2. New subsection (h) and subsection relettering filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

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§9771. Applications for Certification.

(a) Any of the following entities may apply for certification as a health care organization:

(1) A disability insurer licensed by the Department of Insurance to transact health insurance or disability income insurance pursuant to Part 2 of Division 2 of the Insurance Code.

(2) Any workers compensation health care provider organization.
(b) An applicant must meet all of the requirements set forth in this article in order to be certified as a health care organization by the administrative director. Applicants must initially submit to the administrative director, as part of the application, a plan which will provide a clear and concise description of how occupational medical and health care services are to be provided and how each of the requirements in this article are met, and, where specified, in the manner required under each section. HCOs must include all documentation necessary to demonstrate that they meet the requirements for certification.

(c) Health care service plans must provide written certification that at the time of application the applicant is not in violation of any provision of law or rules or orders of the Director of the Department of Managed Health Care, and that there are no outstanding orders, undertakings, or deficiency letters which involve the applicant. Disability insurers must provide written certification that at the time of application they are in good standing with the Department of Insurance. The requirement of this subdivision may be satisfied by verified statement under penalty of perjury by the president or managing officer of an applicant that the applicant meets the requirements of this subdivision, subject to verification by the administrative director.
(d) An applicant who is in compliance with requirements for certification by the Department of Insurance may submit copies of any relevant exhibits, sections or other documents submitted as part of the primary certification application to meet any of the requirements of this article, provided that the applicant (1) verifies that the Department of Insurance has fully reviewed and approved the submitted information, (2) provides a concise narrative identifying any manner in which HCO services will be provided differently from those provided under the primary certification, and (3) provides a concise description for each requirement of this article, specifying how occupational medical and health care services or other services specifically and exclusively required by this article will be met.

(e) Applications must be in writing in the form and manner prescribed by the administrative director, and must be submitted on or after January 1, 1994. The original plus one copy of the application shall be submitted together with a fee as specified in subdivision (c). Each application shall provide, in addition to the plan specified in subdivision (b), the following information:

(1) The names of all directors and officers of the health care organization;

(2) The title and name of the person designated to be the day-to-day administrator of the health care organization.

(3) The title and name of the person designated to be the administrator of the financial affairs of the health care organization.

(4) The name, medical specialty, if any, board certification, if any, and any unrestricted licenses (including states where licensed), of the medical director.

(5) The name, address, and telephone number of a person designated to serve as a liaison for the Division, who is responsible for receiving compliance and informational communications from the Division and for disseminating the same within the HCO organization.

(6) A sample of each type of contract with participating providers, claims administrators, and insurers, and any entities specifically providing services required by this article; and a list of contractors for each type of contract. Copies of contracts shall be made available to the administrative director upon request. The Division will maintain as confidential information pertaining to provider rates and other financial information in accordance with Government Code Section 6254(d)(1).

(7) An organizational chart demonstrating the structural relationships between the medical director, fiscal or financial administrator, and executive officers and administrators.

(8) The identity of any worker's compensation insurer that controls or is controlled by the applicant, as defined by Section 1215 of the Insurance Code.

(f) Each application for certification must be accompanied by a non refundable fee of $2,500.

(g) In lieu of an application for certification, an entity licensed as a full service health care service plan under Section 1353 of the Health and Safety Code (a Knox-Keene Health Care Service Plan Act) and deemed to be an HCO pursuant to Labor Code Section 4600.5(c) shall submit to the administrative director:

(1) a concise description of how the health plan will satisfy the requirements of Labor Code Section 4600.5(c)(1 - 5) and Sections 9772 through 9778, inclusive, of these regulations. At the time the materials required by this subsection are submitted to the administrative director for review, the health plan shall pay a nonrefundable documentation processing and review fee of $1,000; and,

(2) written certification that the health plan is not in violation of any provisions of law or rules or orders of the Director of the Department of Managed Health Care, and that there are no outstanding orders, undertakings, or deficiency letters which involve the health plan. The requirements of this subdivision may be satisfied by verified statement under penalty of perjury by the president or managing officer of the health plan that the plan meets the requirements of this subdivision, subject to verification by the administrative director.

Note: Authority cited: Sections 133, 4600.5, 4600.7, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600 and 4600.5, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

2. Amendment of subsection (d), new subsection (e)(8) and amendment of subsection (f) filed 2-14-96; operative 2-14-96. Submitted to OAL for printing
only pursuant to Government Code section 11351 (Register 96, No. 7).

3. Repealer of subsection (a)(1), subsection renumbering, amendment of newly designated subsection (a)(2) and subsections (c), (d) and (f), new subsections (g)-(g)(2) and amendment of Note filed 1-9-2003; operative 1-9-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 2).

4. Amendment of subsections (f) and (g)(1) filed 11-4-2009; operative 1-1-2010 (Register 2009, No. 45).

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§9771.1 Updating Applications.

(a) Every application submitted under Section 9771(e) shall be kept current to reflect accurately the actual operation of the HCO. An applicant or a certified HCO shall file an amendment to its application to show any change in any information contained in the application. Amendments include changes, deletions, additions and variations to the original application and its exhibits, including sample contracts. Amendments shall be filed as set forth in this section. However, the administrative director may approve an alternative form of submitting an amendment if it substantially accomplishes the purposes of this section.

(b) An original and one copy of an amendment shall be submitted to the administrative director as follows:

(1) Submit an Execution Page of the application, indicating it is an "Amendment to Pending Application" or "Amendment to Application of a Certified Organization";

(2) Furnish only those pages of the application and/or those exhibits which are changed by the amendment.

(3) If a page of the application is amended, complete all items on that page and "redline" or otherwise clearly designated the changed item. At the lower left-hand corner of each page, type "Rev. [date]", giving the effective date of the amendment.

(4) If an exhibit is being amended:

(A) Furnish the complete exhibit as amended, bearing the same number as the original exhibit, with the changed portions of the exhibit "redlined" or otherwise clearly designated, or

(B) Furnish the pages of the exhibit which are amended, each page to be marked with the exhibit number and the page number of the exhibit, and with the changed portions "redlined" or otherwise clearly designated. At the lower left-hand corner of each page, type "Rev. [date]", giving the effective date of the amendment. If this method of amendment is employed, the applicant shall refile the entire exhibit as amended whenever more than 10 percent if its pages have been amended.

(2) In the event that it is impossible to submit a proposed material change in the application 30 days before the change is implemented, the applicant shall submit the change as soon as the applicant becomes aware that a change is required. If, in the opinion of the administrative director, the change or proposed changed raises a question as to the ability of a certified HCO to meet the requirements of this article, the administrative director may, within 30 days of receiving notice of the change inform the HCO of the question. When the administrative director informs the HCO that a question exists, the HCO may not implement the proposed change, or shall cease implementing the change. The

HCO may submit whatever materials it deems appropriate to justify the amendment and may meet with the administrative director or staff to discuss the question. Within 30 days after informing the HCO of the question, the administrative director shall inform the HCO whether the amendment is approved or disapproved.

(d) Amendments making non-material changes shall be filed quarterly on dates specified by the administrative director. However, a list of providers need be amended only when 10 percent or more of the names contained in the list for a service area have been changed or when the sole or principal provider for a particular health care service in a service area is added or deleted. When amended, the complete list (or the list for the service area) shall be furnished following the instructions for the particular item, with each added "redlined" or otherwise clearly designated and the names of persons deleted from the list shown at the end under the heading "deletions."

(e) Review of amendments submitted under section 9771.1, except quarterly updates under section 9771.1(e)(2), will be charged based on the actual cost for performing the review. The amount shall include the actual salaries or compensation paid to the persons reviewing amendment; the expenses incurred in the course thereof, and overhead costs in connection therewith as fixed by the Administrative Director. Overhead costs shall be based on the total expenditure for operating expenses and equipment, except travel, of the managed care unit of the Division of Workers' Compensation for the previous fiscal year. The invoice will be sent upon the completion of the review and shall be paid within 30 calendar days.

NOTE: Authority: Sections 133, 4600.5, 4600.7, 5307.3, Labor Code. Reference: Sections 4600.3, 4600.5, Labor Code.

HISTORY

1. New section filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

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§9771.2 Information to Be Furnished as it Becomes Available.

(a) If an HCO, or any person listed in section 9771(e)(8), is named as a defendant in a lawsuit that is materially related to the provision of medical treatment under Labor Code section 4600, the HCO shall inform the administrative director within 5 days of the day it becomes aware the suit is filed and shall provide a copy of the complaint.

(b)(1) If a certified HCO is a health care services plan and if the Director of the Department of Managed Health Care begins proceedings against the plan under Articles 7 or 8 of the Knox-Keene Health Care Service Plan Act of 1975, the certified HCO shall inform the administrative director within 5 days of the day it becomes aware of the proceedings. The requirements of this subdivision shall also apply to an HMO deemed an HCO pursuant to Labor Code Section 4600.5(c) while the administrative director is reviewing the documentation required by Section 9771 subdivisions (g)(1) and (2) prior to issuing the HMO its certification.

(2) If an applicant or a certified HCO is a disability insurer and if the Commissioner of Insurance begins proceedings against the insurer under Insurance Code section 704 or an examination under section 730, the applicant or certified HCO shall inform the administrative director within 5 days of the day it becomes aware of the proceedings or examination.

(c) A change in the information required by Section 9771(e) (1), (2), (3), (4), (5), and (8) shall be submitted within 5 days of the change.

(d) If an applicant or an affiliate of an applicant enters a contract whereby the applicant is to be purchased by or otherwise come under the control of another entity, the applicant shall notify the administrative director within 5 days of entry into the contract.

NOTE

Authority: Sections 133, 4600.5, 5307.3, Labor Code. Reference: Sections 4600.3, 4600.5, Labor Code.

HISTORY

1. New section filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

2. Amendment of subsection (b)(2) and repealer of subsection (b)(3) filed 1-9-2003; operative 1-9-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 2).

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§9771.6 Application of Regulations Concerning Workers' Compensation Health Care Provider Organizations.

Sections 9771.6 through 9771.83 apply only to workers' compensation health care organizations as defined by Section 9771.60(m).

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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§9771.60 Further Definitions.

The following definitions apply to the interpretation of these rules and the Act:

(a) “Act” means Sections 4600.3, 4600.5 and 4600.6 of the Code

(b) “Advertisement” includes the disclosure form required pursuant to Section 4600.6(e) of the Code.

(c)(1) An “affiliate” of a person is a person controlled by, under common control with, or controlling such person.

(2) A person's relationship with another person is that of an “affiliated person” if such person is, as to such other person, a director, trustee or a member of its executive committee or other governing board or committee, or that of an officer or general partner, or holds any other position involving responsibility and authority similar to that of a principal officer or general partner; or who is the holder of 5 percent or more of its outstanding equity securities; or who has any such relationship with an affiliate of such person. An affiliate is also an affiliated person.

(d) The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting shares, debt, by contract, or otherwise.

(e) The term “certified” or “audited,” when used in regard to financial statements, means examined and reported upon with an opinion expressed by an independent public or certified public accountant.

(f) “Code” means the California Labor Code.

(g) “Administrative Director” means the Administrative Director of the Division of Workers' Compensation.

(h) “Facility” means

(1) any premises owned, leased, used or operated directly or indirectly by or for the benefit of an organization or any affiliate thereof, and

(2) any premises maintained by a provider to provide services on behalf of an organization.

(i) “Material”: A factor is “material” with respect to a matter if it is one to which a reasonable person would attach importance in determining the action to be taken upon the matter.

(j) “Principal creditor” means

(1) a person who has loaned funds to another for the operation of such other person's business, and

(2) a person who has, directly or indirectly, 20 percent or more of the outstanding debts of a person.

(k) “Principal officer” means a president, vice-president, secretary, treasurer or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

(l) The term “generally accepted accounting principles,” when used in regard to financial statements, assets, liabilities and other accounting items, means generally accepted accounting principles as used by business enterprises organized for profit. Accordingly, Financial Accounting Standards Board statements, Accounting Principles Board opinions, accounting research bulletins and other authoritative pronouncements of the accounting profession should be applied in determining generally accepted accounting principles unless such statements, opinions, bulletins and pronouncements are inapplicable. Section 510.05 of the AICPA Professional Standards, in and of itself, shall not be sufficient reason for determining inapplicability of statements, opinions, bulletins and pronouncements.

(m) Workers' compensation health care provider organization” or “organization” means an entity authorized by the Administrative Director to be a health care organization pursuant to Section 4600.5(e) and 4600.6, or an entity applying for such authorization.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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§9771.61 Prohibition of Bonuses or Gratuities in Solicitations.

No person subject to the provisions of the Act shall offer or otherwise distribute any bonus or gratuity to a potential self-insured employer, group of self-insured employers, or insurer of an employer for the purpose of inducing enrollment or to an existing self-insured employer, group of self-insured employers, or insurer of an employer for the purpose of inducing the continuation of enrollment.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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§9771.62 Application for Authorization as a Workers' Compensation Health Care Provider Organization.

(a) An application for authorization as a workers' compensation health care provider organization shall be filed in the form specified in subsection (c) and contain the information specified in this section.

(b) Applications will be processed in the order in which they are filed; provided however, that applications under Section 4600.5(f)(2) shall have priority.

(c) Application Form (WHWCPO-1).

DIVISION OF WORKERS' COMPENSATION

SUPPLEMENTARY APPLICATION

UNDER LABOR CODE SECTION 4600.6.

Date of Application:

WORKERS' COMPENSATION HEALTH CARE PROVIDER

ORGANIZATION AUTHORIZATION

APPLICATION LABOR CODE SECTION 4600.6 (EXECUTION PAGE)

Identification of Organization.

Name of Applicant.

a. Legal name:

b. Please list all fictitious names you intend to use

A. Type of Filing: Indicate the type of filing by checking and completing the appropriate items:

1. ( ) Original application for organization authorization.

2. ( ) Amendment #___ to a pending application dated _____ for organization authorization. (Complete Item A-5 below.)

3. ( ) Notice of a proposed material modification (Complete Item A-5 below.)

4. ( ) Amendment filed by an organization because of a change in the information contained in the original application. (Complete Item A-5 below.)

5. Item numbers being amended

Exhibit numbers being amended

B. Other Agencies.

1. If applicant has made or intends to make any filing relating to its plan of operation to any other state or federal agency, check here ___, and attach Exhibit B-1 identifying each such agency, and the nature, purpose and (projected) date of each such filing.

Additional Exhibits: An original application for organization authorization must include the completed form specified in this subsection and the exhibits required.

C. Summary of Information in Application.

1. Summary Description of Organization and Operation. Provide as Exhibit C-1 a summary description of the organization and operation of applicant's business as a workers' compensation health care provider organization, covering the highlights and essential features of the information provided in response to the other portions of this application which is essential or desirable to an effective overview of the applicant's workers' compensation health care business, including a summary of the applicant's experience in the provision of workers' compensation health care.

2. Summary Description of Start-up. Provide as Exhibit C-2 a concise description of applicant's start-up program and its assumptions, including such program's operating, capitalization and financial assumptions. Indicate applicant's projected date for the beginning of operations, and discuss the factors which require such date.

D. Organization and Affiliated Persons.

1. Type of Organization.

a. Corporation. If applicant is a corporation, attach as Exhibits D-1-a-I, D-1-a- ii, D-1-a-iii and D-1-a-iv respectively, the Articles of Incorporation, Bylaws, the Corporation Information Form (Form WCHCPO 1-A) and any other organizational documents or agreements relating to the internal affairs of the applicant.

b. Partnership. If applicant is a partnership, attach as Exhibits D-1-b-I, D-1-b- ii and D-1-b-iii respectively, the Partnership Agreement, the Partnership Information Form (Form WCHCPO 1-B) and any other organizational documents or agreements relating to the internal affairs of the applicant.

c. Sole Proprietor. If applicant is a sole proprietorship, attach as Exhibit D-1-c the Sole Proprietorship Information Form. (Form WCHCPO 1-C)

d. Other Organization. If applicant is any other type of organization, attach as Exhibit D-1-d Articles of Association, trust agreement, or any other applicable documents, and any other organizational documents or agreements relating to the conduct of the internal affairs of the applicant, and attach as Exhibit D-1-d-ii the Information Form for other than Corporations, Partnerships, and Sole Proprietorships. (Form WCHCPO 1-D)

e. Individual Information Sheet. Attach as Exhibit D-1-e, an Individual Information Sheet (Form WCHCPO 2) for each natural person named in any exhibit in Item D-1.

2. Contracts with Affiliated Persons, Principal Creditors and Providers of Administrative Services.

a. Persons to Be Identified. Attach as Exhibit D-2-a, a list identifying each individual or entity who is a party to a contract with applicant, if such contract is one for the provision of administrative services to the applicant or any such party is an Affiliated Person or Principal Creditor (Rule 9771.60(c) and (j)) of the applicant. As to each such person, show the following information in columnar form:

(i) The names in alphabetical order.

(ii) The exhibit and page number of the contract (including loans and other obligations).

(iii) The type of contract or loan.

(iv) Each relationship which such individual or entity bears to the applicant (officer, director, partner, trustee, member, Principal Creditor, employee, administrative services provider, health care services provider, or shareholder).

3. Other Controlling Persons. Does any individual or entity not named as a contracting party in Item D-2 or any exhibit thereto have any power, directly or indirectly, to manage, influence, or administer the operation, or to control the operations or decisions, of applicant?

If the appropriate response to this item is “yes,” attach as Exhibit D-3 a statement identifying each such person or entity and explaining fully such person's power or control, and summarizing every contract or other arrangement or understanding (if any) with each such person. (Each such contract should be submitted pursuant to Subsection D-2.)

4. Criminal, Civil and Administrative Proceedings. Within the preceding 10 years, has the applicant, its management company, or any Affiliate of the applicant (Rule 9771.60(c)), or any controlling person, officer, director or other person occupying a principal management or supervisory position in such organization, management company or Affiliate, or any person intended to hold such a relationship or position, been convicted of or pleaded nolo contendere to a crime, or been held to have committed any act involving dishonesty, fraud or deceit in a judicial or administrative proceeding to which such person was a party?

If “yes,” attach a separate exhibit as to each such person designated Exhibit D-4, identifying such person and fully explaining the crime or act committed. Also, attach a copy of the exhibit to any Individual Information Sheet required by Item D-1-e for such individual.

5. Employment of Barred Persons. Has the organization engaged or does the organization intend to engage, as an officer, director, employee, associate, or provider, any person named in (i) any order of the Commissioner pursuant to Section 1386(c) or Section 1388(d) of the Knox-Keene Health Care Service Plan Act of 1975, (ii) any similar order of the Insurance Commissioner under the Insurance Code barring or otherwise prohibiting such person from being employed or otherwise engaged as an officer, director, employee, associate or provider of any entity subject to the jurisdiction of the Insurance Commissioner, or (iii) any administrative orders issued by a professional licensing board or by the Department of Industrial Relations? If the appropriate response to this item is “yes,” attach as Exhibit D-5 a statement identifying each such person and explaining fully the scope of, and the circumstances giving rise to, such order.

E. Contracts with Providers.

1. Compliance with Requirements. Attach as Exhibit E a statement in tabular form for each provider contract, and for each standard form contract and its variations, if any, specifying the provisions of such contract which comply with the following provisions of the Act and rules:

Section 4600.6(g)

4600.6(I)(8)

4600.6(n)

Rules 9771.69

9771.70

9772 through 9778

2. The provisions describing the mechanism by which payments are to be rendered to the provider clearly identified by the name of the provider.

F. Workers' Compensation Health Care Contracts.

Compliance with Requirements. Attach as Exhibit F a schedule in tabular form for each workers' compensation health care contract and each standard form workers' compensation contract, identifying the particular provision of such contract which complies with the sections listed below, covering also any variations made in standard form contracts. As to any provision which varies from the applicable provision of the Act or rules, identify such provision in Exhibit F.

Section 4600.5(e)(7)(B)

4600.6(e)

Rules 9771.67

9771.69

9772 - 9778

G. Advertising.

Attach as Exhibit G a copy of any advertising which is subject to Section 4600.6 of the Code and which applicant proposes to use. With respect to each proposed advertisement indicate the contract(s) by name and by exhibit number(s) to which such advertisement relates and identify the employer segment to which the advertisement is directed.

H. Marketing of Workers' Compensation Health Care Contracts.

Attach as Exhibit H a statement describing the methods by which applicant proposes to market workers' compensation health care contracts, including the use of employees, or contracting solicitors or solicitor firms, their method or form of compensation, and the methods by which applicant will obtain compliance with Rules 9771.64, 9771.65, and 9771.83.

I. Supervision of Marketing.

Attach as Exhibit I a statement setting forth applicant's internal arrangements to supervise the marketing of its workers' compensation health care contracts, including the name and title of each person who has primary management responsibility for the employment and qualification of solicitors, advertising, contracts with solicitors and solicitor firms and for monitoring and supervising compliance with contractual and regulatory provisions.

J. Solicitation Contracts.

1. Attach as Exhibit J-1 a list of all persons (other than any employee of the organization whose only compensation is by salary) soliciting or agreeing to solicit the sale of workers' compensation health care contracts on behalf of the applicant. For each such person, identify by exhibit number that person's contract furnished pursuant to Item K-2 and, if such contract does not show the rate of compensation to be paid, specify the person's rate of compensation.

2. Attach as Exhibit J-2, a copy of each contract or proposed contract between applicant and the persons named in

Exhibit J-1 for soliciting the sale of or selling workers' compensation health care contracts on behalf of applicant. If a standard form contract is used, furnish a specimen of the form, identify the provision and terms of the form which may be varied and include a copy of each variation.

K. Workers' Compensation Health Care Contract Enrollment Projections.

Note: All projections are to cover the period commencing from the applicant's commencement of operations as an authorized and certified workers' compensation health care provider organization for two years.

1. Projections. Attach as Exhibit K-1 projections of applicant's enrollments under workers' compensation health care provider contracts with self-insured employers, groups of self-insured employers, or insurers of employers (individually, “Employer”; collectively, “Employers”) for the periods specified in the above note. Exhibit K-1 is to contain the following information with respect to each anticipated workers' compensation health care contract:

a. The name of the Employer.

b. The number of potential employees eligible to receive workers' compensation health care from the organization who are employed by the Employer.

c. The locations within and around applicant's service area in which the potential employees live and work.

d. The estimated date (or period after authorization by the Administrative Director and certification by the Workers' Compensation Division of the Department of Industrial Relations) for entry into the workers' compensation health care contract.

e. Identification of the workers' compensation health care contract anticipated with the Employer, by reference to Exhibit F. If more than one type of workers' compensation health care contract is expected with an Employer, each contract must be covered separately.

f. The projected number of employees on a monthly basis for the initial period specified in the Note, above, and quarterly for the following year.

2. Substantiation of Projections. Attach as Exhibit K-2 for each workers' compensation health care contract specified in Exhibit K-1 a description of the facts and assumptions used in connection with the information specified in that exhibit and include documentation of the source and validity of such facts and assumptions.

3. Letters of Interest. Attach as Exhibit K-3 letters of interest or intent from each Employer listed in Exhibit K-1, on the letterhead of the Employer and signed by its representative.

L. (Reserved for future use.)

M. Current Viability.

1. Financial Statements.

a. Attach as Exhibit M-1-a the most recent audited financial statements of applicant, accompanied by a report, certificate, or opinion of an independent certified public accountant, together with all footnotes to such financial statements.

b. If the financial statements attached as Exhibit M-1-a are for a period ended more than 60 days before the date of filing of this application, also attach as Exhibit M-1-b financial statements prepared as of date no later than 60 days prior to the filing of this application consisting of at least a balance sheet, a statement of income and expenses, and any accompanying footnotes; these more recent financial statements need not be audited, so long as they are prepared in accordance with generally accepted accounting principles.

2. Provision for Extraordinary Losses. The following requirements require an initial applicant to submit legible copies

of the actual policies of insurance (including any riders or endorsements) or specimen copies of the policies of insurance which show all of the terms and conditions of coverage, or with respect to those items expressly allowing for self-insurance, allow applicant to provide evidence of self-insurance at least as adequate as insurance coverage.

a. Attach as Exhibit M-2-a evidence of adequate insurance coverage or self- insurance to respond to claims for damages arising out of furnishing workers' compensation health care (malpractice insurance).

b. Attach as Exhibit M-2-b evidence of adequate insurance coverage or self-insurance (e.g., appropriate reserve set aside to fund likely liabilities associated with uninsured costs) to respond to claims for tort claims, other than with respect to claims for damages arising out of furnishing health care services.

c. Attach as Exhibit M-2-c evidence of adequate insurance coverage or self-insurance to protect applicant against losses of facilities upon which it has the risk of loss due to fire or other causes. Identify facilities covered by individual policies and indicate the basis upon which applicant believes that the insurance thereon is adequate.

d. Attach as Exhibit M-2-d, evidence of fidelity bond coverage for at least the amounts specified in Rule 9771.74, in the form of a primary commercial blanket bond or a blanket position bond written by an insurer licensed by the California Insurance Commissioner, providing 30 days' notice to the Administrative Director prior to cancellation, and covering each officer, director, trustee, partner and employee of the organization, whether or not compensated.

e. Attach as Exhibit M-2-e evidence of adequate workers' compensation insurance coverage against claims which may arise against applicant.

N. Fiscal Arrangements.

1. Maintenance of Financial Viability. Attach as Exhibit N-1 a statement describing applicant's arrangements to comply with Section 4600.6(m) of the Code and Rule 9771/73.

2. Provider Claims. Attach as Exhibit N-2 a statement describing applicant's system for processing claims from providers for payment, including the rules defining applicant's obligation to reimburse, the standards and procedures for applicant's claims processing system (including receipt, identification, handling, screening, and payment of claims), the timetable for processing claims, and procedures for monitoring the claims processing system.

3. Other Business. If the applicant is or will engage in any business other than as a workers' compensation health care provider organization, attach as Exhibit N-3 a statement describing such other business, its relationship to applicant's business as an organization, and the anticipated financial risks and liabilities of such other business. If the financial statements and projections in Exhibits M-1-a, do not include such other business, explain.

(d) Information Forms Required by Item D-1:

(1) Corporation Information Form (WCHCPO 1-A).

STATE OF CALIFORNIA

DIVISION OF WORKERS' COMPENSATION

D-1-a-iii CORPORATION

INFORMATION FORM

To be used in response to Item D-1-a of Form WCHCPO 1.

1. Name of Applicant (as in Item 1-a)

2. State of Incorporation.

3. Date of Incorporation.

4. Is applicant a nonprofit corporation? ( ) Yes ( ) No

5. Is applicant exempted from taxation as a nonprofit corporation? ( ) Yes ( ) No

6. Names of principal officers, directors and shareholders: List (a) each person who is a director or principal officer or who performs similar functions or duties and (b) each person who holds of record or beneficially 5 percent or more of the voting securities of applicant or 5 percent or more of applicant's equity securities. If this is an amended exhibit, place an asterisk (*) before the names for whom a change in title, status or stock ownership is being reported and a double asterisk (**) before the names of persons which are added to those furnished in the most recent previous filing.

Full Name Beginning Type of Capital Titleor

Last First Middle Date Partner Contribution Duties

Mo. Year (percentage)

7. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

(2) Partnership Information Form (WCHCPO 1-B)

STATE OF CALIFORNIA

DIVISION OF WORKERS' COMPENSATION

EXHIBIT D-1-ii PARTNERSHIP

INFORMATION FORM.

To be used in response to Item D-1-b of Form WCHCPO 1.

1. Name of Applicant (as in Item 1-a).

2. State of organization.

3. Date of organization.

4. Names of Partners and Principal Management: List all general, limited and special partners and all persons who perform principal management functions. If this is an amended exhibit, place an asterisk (*) before the names of persons for whom a change in title, status or partnership interest is being reported and place a double asterisk (**) before the names of persons which are added to those furnished in the most recent previous filing.

Full Name Beginning Type of Capital Title or

Last First Middle Date Partner Contribution Duties

Mo. Year (percentage)

5. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

(3) Sole Proprietor Information Form (WCHCPO 1-C).

STATE OF CALIFORNIA

DIVISION OF WORKERS' COMPENSATION

EXHIBIT D-1-c SOLE PROPRIETORSHIP

INFORMATION FORM

To be used in response to Item D-1-c of Form WCHCPO 1.

1. Name of Applicant (as in Item 1-a).

2. Residence Address.

3. Names of persons performing principal management functions: List each person who occupies a principal management position or who performs principal management functions for the applicant. If this is an amended exhibit, place an asterisk (*) before the names of persons for whom a change in title or duties is being reported and place a double asterisk (**) before the names of persons which are being added to those furnished in the most recent previous filing of this exhibit.

Full Name Beginning Title and

Last First Middle Date Duties

Mo. Year

4. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

(4) Information Form for Miscellaneous Types of Entities (WCHCPO 1-D).

STATE OF CALIFORNIA

DIVISION OF WORKERS' COMPENSATION

EXHIBIT D-1-d INFORMATION FORM FOR

MISCELLANEOUS TYPES OF ENTITIES.

To be used in response to Item D-1-d of Form WCHCPO 1.

1. Name of Applicant (as in Item 1-a)

2. State of Organization

3. Date of Organization

4. Form of Organization (describe briefly)

5. Names of Principal Officers and Beneficial Owners: List below the names of (a) each person who is a principal officer or trustee of the applicant or who performs principal management functions, and (b) each person who owns of record or beneficially over 5 percent of any class of equity security of the applicant. If this is an amended exhibit, place an asterisk (*) before the name of each person for whom a change in title, status or interest is reported, and a double asterisk (**) before the name of persons which are added to those reported in the most recent previous filing.

Full Name Beginning Class of Equity Percent of Title and

Last First Date Security Class Duties

Mo. Year

6. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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New query

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§9771.63 Individual Information Sheet (WCHCPO 2).

An individual information sheet required pursuant to these rules shall be in the following form:

CONFIDENTIAL

DIVISION OF WORKERS' COMPENSATION

State of California

INDIVIDUAL INFORMATION SHEET

under Labor Code Section 4600.6

1. Name of Applicant: File No._____

2. Exact full name of person completing this statement:

First Middle Last

3. Have you ever had a certificate, license, permit registration or exemption issued pursuant to the Business and Professions Code, Health and Safety Code, Insurance Code, or Labor Code denied, revoked or suspended or been otherwise subject to disciplinary action, while you were in the employ of the applicant, or while you had a contract with the applicant as a provider or otherwise? [ ] Yes [ ] No

If “yes” state the date of the action and the administrative body taking such action.

4. Have you ever been convicted or pled nolo contendere to a misdemeanor involving moral turpitude or any felony, other than traffic violations? [ ] Yes [ ] No

If the answer is “yes” give details:

5. Have you ever changed your name or ever been known by any name other than that herein listed? (Including a married person's prior surname, if any.) [ ] Yes [ ] No

If so, explain. Change in name through marriage or court order should also be listed. EXACT DATE OF EACH NAME CHANGE MUST BE LISTED.

6. Have you ever engaged in business under a fictitious firm name either as an individual or in the partnership or corporate form? [ ] Yes [ ] No

If the answer is “yes” set forth particulars:

VERIFICATION

I, the undersigned, state that I am the person named in the foregoing Individual Information Sheet, that I have read and signed said Individual Information Sheet and know the contents thereof, including all exhibits attached thereto; and that the statements made therein, including any exhibits attached thereto, are true and correct.

I certify (or declare) under penalty of perjury under the laws of the State of California that I have read this Individual Information Sheet and the exhibits thereto and know the contents thereto, and that the statements therein are true and correct.

Executed at _____on

(Place) (Date)

_____

(Signature of Declarant)

Note: If this form is signed outside California complete the verification before a notary public in the space provided below.

State of

County of

Dated,

at

(Signature of Affiant)

Subscribed and sworn to before me,

Notary Public in and for said

County and State

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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New query

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§9771.64 Organization Assurances Prior to Solicitation.

Prior to allowing any person to engage in acts of solicitation on its behalf, each organization shall reasonably assure itself that such person has sufficient knowledge of its organization, procedures, workers' compensation health care contracts, and the provisions of the Act and these rules to do so lawfully.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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§9771.65 Filing of Advertising and Disclosure Forms.

(a) Two copies of a proposed advertisement shall be filed. To minimize the expense of changes in advertising copy, it may be submitted in draft form for preliminary review subject to the later filing of a proof or final copy, and the later filing of a proof or final copy may be waived when the draft copy is presented in a manner reasonably representing the final appearance of the advertisement. The text of audio or audio/visual advertising should indicate any directions for presentation, including voice qualities and the juxtaposition of the visual materials with the text.

(b) The Administrative Director will not issue letters of nondisapproval of advertising. If the person submitting the advertisement requests an order shortening the 30-day waiting period under Section 4600.6(d) of the Code, such order will be issued when an appropriate showing of the need therefor is made.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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§9771.66 Deceptive Advertising.

Without limitation upon the meaning of Section 4600.6 of the Code, an advertisement or other consumer information is untrue, misleading or deceptive if:

(a) It represents that payment is provided in full for the charge for workers' compensation health care other than in accordance with what is required under the Labor Code.

(b) It represents that payment is provided for the customary charges for workers' compensation health care other than in accordance with what is required under the Labor Code.

(c) It represents that the organization, firm or solicitor or any provider or other person associated therewith is licensed or regulated by the Department of Managed Health Care or Administrative Director or other governmental agency, unless such statement is required by law or regulation or unless such statement is accompanied by a satisfactory statement which counters any inference that such licensing or regulation is an assurance of financial soundness or the quality or extent of workers' compensation health care.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

2. Amendment of subsection (c) filed 1-9-2003; operative 1-9-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 2).

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§9771.67 Disclosure Form.

(a) The disclosure form required under subdivision (a) of Section 4600.6(e) of the Code and made available to employers and employees shall conform to the requirements established by the Administrative Director of the Division of Workers' Compensation of the Department of Industrial Relations (Cal. Code Regs., Tit. 8, Sec. 9770 et seq.).

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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§9771.68 Deceptive Workers' Compensation Health Care Provider Organization Names.

(a) A change of organization name is a “material modification”.

(b) An organization name will be considered deceptive if it suggests the quality of care furnished by the organization or if it suggests that the cost of workers' compensation health care provided to employees is lower than the cost of similar health care purchased elsewhere, and in any such case the express or implied representation contained in the organization name is demonstrably untrue or is not supported by substantial evidence at all times while such name is used by the organization. Nothing in this subsection limits or restricts the Administrative Director from a determination that an organization or solicitor firm name is deceptive for reasons other than those stated herein.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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New query

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§9771.69 Workers' Compensation Health Care Contracts.

(a) All workers' compensation health care contracts and endorsements and amendments shall be printed legibly and shall include at least the following:

(1) The information required to be included on disclosure forms by Section 4600.6(e) of the Code and the information required to be included on disclosure forms by Rule 9771.67.

(2) Definitions of all terms contained in the contract which:

(A) Are defined by the Act, relevant Labor Code provisions, and the Regulations of the Administrative Director.

(B) Require definition in order to be understood by a reasonable person not possessing special knowledge of law, medicine, or organizations;

(C) Specifically describes the eligibility of employees.

(3) Appropriate captions, in boldface type, regarding the provision of workers' compensation health care, consistent with the requirements of the certification standards for health care organizations promulgated by the Administrative Director of the Division of Workers' Compensation of the Department of Industrial Relations (Cal. Code Regs., Tit. 8, Sec. 9770, et seq.).

(A) A benefit afforded by the contract shall not be subject to any limitation, exclusion, exception, reduction, deductible, or copayment, if any, which renders the benefit illusory.

(4) Provisions relating to cancellation under appropriate caption, in boldface type, which provisions shall include a statement of the time when a notice of cancellation becomes effective.

(5) A provision requiring the organization to provide written notice within a reasonable time to the other party of any termination or breach of contract by, or inability to perform of, any contracting provider if the other party may be materially and adversely affected thereby.

(6) A provision requiring a self-insured employer, group of self-insured employers, or insurer of an employer to mail promptly to each employee a legible, true copy of any notice of cancellation of the organization contract which may be received from the organization and to provide promptly to the organization proof of such mailing and the date thereof.

(7) A provision that (i) the organization is subject to the requirements of the Labor Code, the Regulations of the

Administrative Director, and (ii) any provision required to be in the contract by the above shall bind the organization whether or not provided in the contract.

(b) For the purposes of this section:

(1) “Other party” means (A) in the case of a group of self-insured employers, the group representative designated in the contract, and (B) in the case of a self-insured employer or issuer of an employer, the self-insured employer or insurer of an employer and the insured employer.

(2) Any express or implied requirement of notice to the other party, in the context of a contract with a group of self-insured employers, requires notice to the group representative designated in the contract and, with respect to material matters, to the employers and employees under the contract. An organization may fulfill any obligation imposed by this section to notify employers and employees under such contract if the organization provider notice to the group representative designated in the contract, and the contract requires the group representative to disseminate such notice to employers and employees by the next regular communication to the group, but in no event later than 30 days after the receipt thereof.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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§9771.70 Contracts with Providers.

Written contracts must be executed between the organization and each provider of workers' compensation health care which regularly furnishes health care under the organization. All contracts with providers shall be subject to the following requirements:

(a) A written contract shall be prepared or arranged in a manner which permits confidential treatment by the Administrative Director of payment rendered or to be rendered to the provider without concealment or misunderstanding of other terms and provisions of the contract.

(b) The contract shall require that the provider submit claims for workers' compensation health care services to the organization within a reasonable period of time following the delivery of health care services to an employee.

Contracts which contain the following language shall be deemed to meet the timing requirements of this subsection (b), and there shall be no other agreements or other language in the contract which negates or diminishes the effect of the following language:

“[Name of Provider] shall submit claims for the cost of workers' compensation health care services to [Organization] according to the compensation provisions of [Section and paragraph] of this agreement, within 60 days after [Name of Provider] has rendered the workers' compensation health care services to the employee. However, failure to submit claims within 60 days does not alter the obligation of the organization to pay claims of contracting providers for which the organization has received payment.”

(c) The contract shall provide that the organization shall forward claims from providers to the self-insured employer, group of self-insured employers or insurers of employers within 30 days after receipt of the claim from the provider, and that the organization shall pay the provider's claim no later than 30 days after receiving payment from the self-insured employer, group of self-insured employers or insurer of employers.

(d) The contract shall require that the provider maintain such records and provide such information to the organization or to the Administrative Director as may be necessary for compliance by the organization with the provisions of the Code and the rules thereunder, that such records will be retained by the provider for at least five years, and that such obligation is not terminated upon a termination of the agreement, whether by rescission or otherwise. (See Rule 9771.83)

Contracts which contain the following language shall be deemed to meet the requirements of this subsection (d), and there shall be no other agreements or other language in the contract which negates or diminishes the effect of the following language:

“[Name of Provider] shall maintain all books, records of account, medical records, reports and papers as may be necessary for compliance by the organization with the provisions of Labor Code Section 4600.6 and the rules thereunder. All such books, records and reports shall be available to the organization or to the Administrative Director, as necessary or required, under the Act and Rules.

All such books, records, reports and papers must be maintained for at least five years after the initial date of delivery of health care services under this Agreement. The obligation of [Name of Provider] to maintain books, records, reports and papers and to make them available shall not terminate upon the termination of [this Agreement].”

(e) The contract shall require that the organization shall have access at reasonable times upon demand to the books, records and papers of the provider relating to the workers' compensation health care provided to employees, to the cost thereof, to payments received by the provider from the organization, self-insured employer, group of self-insured employers, an insurer of an employer, employee, or from others on the behalf of the foregoing. Contracts which contain the following language shall be deemed to meet the requirements of this subsection

(e), and there shall be no other agreements or other language in the contract which negates or diminishes the effect of the following language:

“The [Organization] shall have access during regular business hours to all administrative, financial and medical books, records reports and papers relating to the delivery of workers' compensation health care to employees, and to the cost of such delivery, payments received by [the Provider] from [the Organization] and/or any self-insured employer, group of self-insured employers, or insurer of an employer, an employee, or others.”

(f) The contract shall prohibit surcharges or other payments in violation of the Labor Code for workers' compensation health care services and shall provide that whenever the organization receives notice of any such surcharge it shall take appropriate action.

(g) The contract shall disclose whether there are any other agreements between the organization and the provider, and shall incorporate by reference all such other agreements. Contracts which contain the following language shall be deemed to meet the requirements of this subsection (g):

“This [Agreement], including all addenda, supersedes any and all other agreements between [the Organization] and [the Provider] which are not attached hereto and incorporated herein and which are related to the delivery of, or to the compensation for, workers' compensation health care services. No future statements or promises relating to the delivery of workers' compensation health care services shall be valid or binding unless written and incorporated herein as addenda, subject to the approval of the Administrative Director”.

(h) The contract shall contain provisions complying with Section 4600.6(n) of the Code and shall comply with the provisions of subsection (a)(7) of Rule 9771.69.

(i) The contract shall require that the provider cooperate with the organization's quality assurance and utilization review system established pursuant to Section 4600.6(k) of the Code, and cooperate with the Administrative Director in accordance with the provisions of Section 4600.6(o) of the Code and Sections 9771.76 and 9771.77 of the Rules.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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§9771.71 Disclosure of Conflicts of Interest.

(a) An organization shall not enter into any transaction with a person currently named in Item D of its application under Rule 9771.62 unless, prior thereto, each of the following conditions is met:

(1) The material facts concerning the transaction and the person's interest therein are disclosed to the governing body of the organization.

(2) The transaction is approved by a disinterested majority of the governing body.

(3) Such facts and such approval are made a part of the minutes of such governing body or, if no minutes are required of such governing body, otherwise retained as a record of the organization.

(b) An organization shall promptly give written notice to the Administrative Director if a transaction with a person currently named in Item D of its application under Rule 9771.62 is entered into otherwise than in conformity with the terms of this section.

(c) For the purposes of this section, “governing body” means the board of directors, all general partners, the sole proprietor, the board of trustees, and any other persons occupying a similar position or performing similar functions.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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§9771.72 Contracts with Solicitor Firms.

An organization shall not permit a solicitor firm to solicit self-insured employers, groups of self-insured employers, or insurers of an employer on its behalf except pursuant to a written contract which meets all of the following minimum requirements:

(a) The solicitor firm shall comply, and shall cause its principal persons and employees to comply, with all applicable provisions of the Act and the rules thereunder.

(b) The solicitor firm shall promptly notify the organization of the institution of any disciplinary proceedings against it or against any of its principal persons or employees relating to any license issued to any such person by the California Insurance Commissioner.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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§9771.73 Fiscal Soundness, Insurance, and Other Arrangements.

(a) An organization shall demonstrate fiscal soundness as follows: Demonstrate an approach to the risk of insolvency which allows for the continuation of health care services for the duration of the contract period, the continuation of health care services to employees who are under treatment or confined on the date of insolvency in an in-patient facility until their discharge, and payments to unaffiliated providers for health care services rendered.

(b) In passing upon an organization's showing pursuant to this section, the Administrative Director will consider all relevant factors, including but not limited to:

(1) The method of compensating providers and the terms of provider contracts, especially as to the obligations of providers to employees in the event of the organization's insolvency.

(2) The methods by which the organization controls and monitors the utilization of health care services.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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§9771.74 Fidelity Bond.

(a) Each organization shall at all times maintain a fidelity bond covering each officer, director, trustee, partner and employee of the organization, whether or not they are compensated. The fidelity bond may be either a primary commercial blanket bond or a blanket position bond written by an insurer licensed by the California Insurance Commissioner, and it shall provide for 30 days' notice to the Administrative Director prior to cancellation. The fidelity bond shall provide at least the minimum coverage for the organization determined by the following schedule:

Annual Minimum

Gross Income Coverage

Up to $ 100,000 $ 10,000

100,000 to 300,000 20,000

300,000 to 500,000 30,000

500,000 to 750,000 50,000

750,000 to 1,000,000 75,000

1,000,000 to 2,000,000 100,000

2,000,000 to 4,000,000 200,000

4,000,000 to 6,000,000 400,000

6,000,000 to 10,000,000 600,000

10,000,000 to 20,000,000 1,000,000

20,000,000 and over 2,000,000

(b) The fidelity bond required pursuant to subsection (a) may contain a provision for a deductible amount from any loss which, except for such deductible provision, would be recoverable from the insurer. A deductible provision shall not be in excess of 10 percent of the required minimum bond coverage, but in no event shall the deductible amount be in excess of $100,000.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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§9771.75 Reimbursements on a Fee-for-Services Basis: Determination of Status of Claims.

Every organization shall institute procedures whereby all claim forms received by the organization from providers of workers' compensation health care for reimbursement on a fee-for-service basis are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time, and rapid retrieval of any claim. Although any categories for status-determination held unobjectionable by the Administrative Director may be used, for the purposes of this section, the following status-determination categories, as a group, shall be presumptively reasonable:

(1) to be processed,

(2) processed, waiting for payment,

(3) pending, waiting for approval for payment or denial,

(4) pending, waiting for additional information,

(5) denied,

(6) paid, and, if appropriate,

(7) other. These procedures shall involve the use of either a claims log, claims numbering system, electronic data processing records, and/or any other method held unobjectionable by the Administrative Director.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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§9771.76 Medical Survey Procedure.

(a) Unless the Administrative Director in his discretion determines that advance notice will render the survey less useful, an organization will be notified approximately four weeks in advance of the date for commencement of an onsite medical survey. The Administrative Director may, without prior notice, conduct inspections of organization facilities or other elements of a medical survey, either in conjunction with the medical survey or as part of an unannounced inspection program.

(b) The onsite medical survey of an organization shall include, but not be limited to, the following procedures to the extent considered necessary based upon prior experience with the organization and in accordance with the procedures and standards developed by the Administrative Director.

(1) Review of the procedures for obtaining workers' compensation health care including, but not limited to, the scope of health care.

(A) The availability and adequacy of facilities for telephone communication with health personnel, emergency health care facilities, out-of-the-area coverage, referral procedures, and medical encounters.

(B) The means of advising employees of the procedures to obtain health care, including the hours of operation, location and nature of facilities, types of health care, telephone and other arrangements for appointment setting.

(C) The availability of qualified personnel at each facility referred to in Section 4600.6(j) of the Code to receive and handle inquiries concerning health care and grievances.

(2) Review of the design and implementation of procedures for reviewing and regulating utilization of health care and facilities.

(3) Review of the design and implementation of procedures to review and control costs.

(4) Review of the design, implementation and effectiveness of the internal quality of care review systems, including review of medical records and medical records systems. A review of medical records and medical records systems may include, but is not limited to, determining whether:

(A) The entries establish the diagnosis stated, including an appropriate history and physical findings;

(B) The therapies noted reflect an awareness of current therapies;

(C) The important diagnoses are summarized or highlighted; (Important are those conditions that have a bearing on

future clinical management.)

(D) Drug allergies and idiosyncratic medical problems are conspicuously noted;

(E) Pathology, laboratory and other reports are recorded;

(F) The health professional responsible for each entry is identifiable;

(G) Any necessary consultation and progress notes are evidenced as indicated;

(H) The maintenance of an appropriate system for coordination and availability of the medical records of the employee, including out-patient, in-patient and referral services and significant telephone consultations.

(5) Review of the overall performance of the organization in providing workers' compensation health care, by consideration of the following:

(A) The numbers and qualifications of health professional and other personnel;

(B) The provision of, incentives for, and participation in, continuing education for health personnel and the provision for access to current medical literature;

(C) The adequacy of all physical facilities, including lighting, cleanliness, maintenance, equipment, furnishings, and convenience to employees, organization personnel and visitors;

(D) The practice of health professionals and allied personnel in a functionally integrated manner, including the extent of shared responsibility for patient care and coordinated use of equipment, medical records and other facilities and services;

(E) The appropriate functioning of health professionals and other health personnel, including specialists, consultants and referrals;

(F) Nursing practices, including reasonable supervision;

(G) Written nondiscriminatory personnel practices which attract and retain qualified health professionals and other personnel;

(H) The adequacy and utilization of pathology and other laboratory facilities, including the quality, efficiency and appropriateness of laboratory procedures and records and quality control procedures;

(I) X-ray and radiological services, including staffing, utilization, equipment, and the promptness of interpretation of X- ray films by a qualified provider;

(J) The handling and adequacy of medical record systems, including filing procedures, provisions for maintenance of confidentiality, the efficiency of procedures for retrieval and transmittal, and the utilization of sampling techniques for medical records audits and quality of care review;

(K) The adequacy, including convenience and readiness of availability to employees, of all provided health care;

(L) How the organization is organized and its mechanisms for furnishing workers' compensation health care, including the supervision of health professionals and other personnel;

(M) The extent to which individual medical decisions by qualified medical personnel are unduly constrained by fiscal or administrative personnel, policies or considerations;

(N) The adequacy of staffing, including medical specialties.

(6) Review of the overall performance of the organization in meeting the health needs of employees.

(A) Accessibility of facilities and workers' compensation health care, based upon location of facilities, hours of operation, waiting periods for health care and appointments, the availability of parking and transportation;

(B) Continuity of health care, including the ability of employees to select a primary treating physician, staffing in medical specialties or arrangements therefor; the referral system (including instructions, monitoring and follow- up); the maintenance and ready availability of medical records; and the availability of health care education to employees;

(C) The grievance procedure required by Section 4600.6(j) of the Code, including the availability to employees of grievance procedure information, the time required for and the adequacy of the response to grievances and the utilization of grievance information by the organization's management.

(7) In considering the above and in pursuit of the survey objectives, the survey team may perform any or all of the following procedures:

(A) Private interviews and group conferences with employees, physicians and other health care professionals and providers, and members of its administrative staff including, but not limited to, persons in principal management positions.

(B) Examination of any records, books, reports and papers of the organization and of any management company, provider or subcontractor providing workers' compensation health care or other services to the organization including, but not limited to, the minutes of medical staff meetings, peer review, and quality of care review records, duty rosters of medical personnel, surgical logs, appointment records, the written procedures for the internal operation of the organization, and contracts and correspondence with employees and with providers of workers' compensation health care and of other services to the organization, and such additional documentation the Administrative Director may specifically direct the surveyors to examine.

(C) Physical examination of facilities, including equipment.

(D) Investigation of grievances or complaints from employees, or from the general public.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

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§9771.77 Medical Survey: Report of Correction of Deficiencies.

Prior to or immediately upon the expiration of the 30-day period following notice to an organization of a deficiency as provided in subdivision (8) of Section 4600.6(o) of the Code, the organization shall file a written statement with the Administrative Director identifying the deficiency and describing the action taken to correct the deficiency and the results of such action. The report shall be signed by a principal officer of the organization. Where such deficiencies reasonably may be adjudged to require long-term corrective action or to be of a nature which reasonably may be expected to require a period longer than 30 days to remedy, evidence that the organization has initiated remedial action and is on the way to achieving acceptable levels of compliance may be submitted for review by the Administrative Director.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

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§9771.78 Removal of Books and Records from State.

The books and records of an organization, management company, solicitor firm, and any provider or subcontractor providing workers' compensation health care or other services to an organization, management company, or solicitor firm shall not be removed from this state without the prior written consent of the Administrative Director.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

1. New section filed 4-15-98; operative 4-15-98. Submitted to OAL for printing only pursuant to Stats. 1997, Ch. 346, Section 5 (Register 98, No. 16).

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§9771.79 Examination Procedure.

Regular and additional or nonroutine examinations conducted by the Administrative Director pursuant to Section 4600.6(q) of the Code will ordinarily be commenced on an unannounced basis. To the extent feasible, deficiencies noted will be called to the attention of the responsible officers of the company under examination during the course of the examination, and in that event the company should take the corrective action indicated. When deemed appropriate, the company will be advised by letter of the deficiencies noted upon the examination. If the deficiency letter requires a report from the organization, such report must be furnished within 15 days or such additional time as may be allowed.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

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§9771.80 Additional or Nonroutine Examinations and Surveys.

(a) An examination or survey is additional or nonroutine for good cause for the purposes of Section 4600.6(q) of the Code when the reason for such examination or survey is any of the following:

(1) The organization's noncompliance with written instructions from the Administrative Director;

(2) The organization has violated, or the Administrative Director has reason to believe that the organization has violated, any of the provisions of Sections 4600.3, 4600.5, or 4600.6 of the Code or regulations referring to those sections.

(3) The organization has committed, or the Administrative Director has reason to believe that the organization has committed, any of the acts or omissions enumerated in Section 4600.5(k) of the Code.

(4) The Administrative Director deems such additional or nonroutine examination or survey necessary to verify representations made to the Administrative Director by an organization in response to a deficiency letter.

(b) Each situation giving rise to an additional or nonroutine examination or survey shall be evaluated on a case-by-case basis as to the seriousness of the violation, or lack of timely or adequate response by the organization to the Administrative Director's request to correct the violation. The organization shall be notified in writing of the provisions of the Act or regulations which have been, or may have been, violated and which therefore caused such additional or nonroutine examination or survey to be performed. The expense of such examinations and surveys shall be charged to the organization being examined or surveyed in accordance with Section 4600.6(q) of the Code.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

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§9771.81 Financial Statements.

(a) Whenever pursuant to these rules or pursuant to an order or request of the Administrative Director under the Code a financial statement or other report is required to be audited or be accompanied by the opinion of a certified public accountant, such accountant shall be independent of the licensee, determined in accordance with Section 602.02 of Financial Reporting Release No. 1 issued by the Securities and Exchange Commission (Securities Act Release 6395, April 15, 1982).

(b) The financial statements shall be audited by an independent accountant in accordance with Rule 9771.60(e).

(c) Except as provided in subsection

(d), financial statements of an organization required pursuant to these rules must be on a combining basis with an affiliate, if the organization or such affiliate is substantially dependent upon the other for the provision of workers' compensation health care, management or other services. An affiliate will normally be required to be combined, regardless of its form of organization, if the following conditions exist:

(1) The affiliate controls, is controlled by, or is under common control with, the organization, either directly or indirectly (see subsections (c) and (d) of Rule 9771.60), and

(2) The organization or the affiliate is substantially dependent, either directly or indirectly, upon the other for services or revenue.

(d) Upon written request of an organization, the Administrative Director may waive the requirement that an affiliate be combined in financial statements required pursuant to these rules. Normally, a waiver will be granted only when

(1) the affiliate is not directly engaged in the delivery of workers' compensation health care or

(2) the affiliate is operating under an authority granted by a governmental agency pursuant to which the affiliate is required to submit periodic financial reports in a form prescribed by such governmental agency that cannot practicably be reformatted into the form prescribed by these rules (such as an insurance company).

(e) When combined financial statements are required by this section, the independent accountant's report or opinion must cover all the entities included in the combined financial statements. If the accountant's report or opinion makes reference to the fact that a part of the examination was performed by another auditor, the organization shall also file the individual financial statements and report or opinion issued by the other auditor.

(f) Organizations which have subsidiaries that are required to be consolidated under generally accepted accounting

principles must present either

(1) consolidating financial statements, or

(2) consolidating schedules for the balance sheet and statement of operations, which in either case must show the organization separate from the other entities included in the consolidated balances.

(g) This section shall not apply to an organization which is a public entity or political subdivision.

(h) All filings of financial statements required pursuant to these rules must include an original and one copy.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

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§9771.82 Books and Records.

(a) Each organization, solicitor firm, and solicitor shall keep and maintain their books of account and other records on a current basis.

(b) Each organization shall make or cause to be made and retain books and records which accurately reflect:

(1) The names and last known addresses of all employees eligible to receive workers' compensation health care, and all contracting self-insured employers, groups of self-insured employers and insurers of employers.

(2) All contracts required to be submitted to the Administrative Director and all other contracts entered into by the organization.

(3) All requests made to the organization for payment of moneys for workers' compensation health care, the date of such requests, and the dispositions thereof.

(4) A current list of the names and addresses of all individuals employed by the organization as solicitors.

(5) A current list of the names and addresses of all solicitor firms with which the organization contracts.

(6) A current list of the names and addresses of all of the organization's officers, directors, principal shareholders, general managers, and other principals.

(7) The amount of any commissions paid to persons who obtain self-insured employers, groups of self-insured employers, and insurers of employers for workers' compensation health care provider organizations, and the manner in which said commissions are determined.

(c) Each solicitor firm shall make and retain books and records which include a current list of the names and addresses of its partners, if any, and all of its employees who make act as solicitors.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

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§9771.83 Retention of Books and Records.

Every organization and solicitor firm shall preserve for a period of not less than five years, the last two years of which shall be in an easily accessible place at the offices of the organization or solicitor firm, the books of account and other records required under the provisions, and for the purposes, of the Act. After such books and records have been preserved for two years, they may be warehoused or stored, or microfilmed, subject to their availability to the Administrative Director within not more than 5 days after request therefore.

NOTE

Authority cited: Stats. 1997, Ch. 346, Section 5. Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

HISTORY

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§9772. General Standards.

(a) HCOs must demonstrate that they meet the following requirements:

(1) All facilities located in this state including, but not limited to, clinics, hospitals, laboratories, and skilled nursing facilities to be utilized by the HCO for the delivery of occupational medical and health care services or other services specifically required by this article shall be licensed by the State Department of Health Services, if such licensure is required by law, and shall meet any other relevant certification requirements. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

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

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

(4) The HCO shall provide continuity of care and timely referral of patients to other providers in a manner consistent with professionally recognized standards of care.

(5) All services shall be available and accessible at reasonable times to all HCO enrollees.

(6) The HCO may employ and utilize allied health personnel for the furnishing of occupational health services to the extent permitted by law and provided such use is consistent with professionally recognized standards of care; however, any course of treatment beyond first aid, as defined in subdivision (c) of Section 14311, shall provide for at least one face to face visit with a primary treating physician.

(7) The HCO shall have the organizational, financial, and administrative capacity to provide services to employers, claims administrators, and HCO enrollees. The HCO shall be able to demonstrate to the Division that medical decisions are rendered by qualified providers unhindered by fiscal and administrative management, and that such decisions adhere to professionally recognized standards of care.

Any applicant that is owned in whole or in part or controlled by a workers' compensation insurer or self-insured employer shall, in addition to the requirements set forth above, further demonstrate that the organization's claims function shall have no influence or control over medical decision-making. The applicant shall further demonstrate that the clear authority of its Medical Director over all medical decisions is reflected both in its organizational chart and any internal procedure manual or other internal description of HCO operations.

(8) All contracts with claims administrators, employers, providers and other persons or entities furnishing services

specifically required by this article shall be consistent with the requirements of this article and Division 4 of the Labor Code.

NOTE

Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code. Reference: Section 4600.5, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

2. Amendment of subsection (b)(7) filed 1-9-2003; operative 1-9-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 2).

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§9773. Treatment Standards.

(a) HCOs shall provide all HCO enrollees with access to all medical, surgical, chiropractic, and hospital treatment which is reasonably required to cure or relieve the effects of an injury in accordance with Section 4600 of the Labor Code. This treatment must be provided without payment of any co-payment, deductible, or premium share by an HCO enrollee. HCOs must provide a description of the method for providing treatment required under the code, including a list of its physical facilities. The description must include the occupational health care delivery capabilities of the HCO, including the number of primary treating physicians and specialists, the number and types of licensed or state-certified health care support staff, the number of hospital beds, and the arrangements and the methods by which occupational health care services will be provided, which shall include the following:

(1) Provider services, including consultation and referral. HCOs must identify the total number of full time equivalent physicians and providers of each different specialty type available to provide treatment for work injuries or illnesses on a regular basis.

(2) Inpatient hospital services, which shall include acute hospital services, general nursing care, use of operating room and related facilities, intensive care unit and services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and other diagnostic, therapeutic and rehabilitative services as medically reasonable or medically necessary, and coordinated discharge planning including planning of such continuing care as may be necessary, both medically and as a means of preventing possible rehospitalization.

(3) Ambulatory care services, (including outpatient hospital services) which shall include diagnostic and treatment services, physical therapy, speech therapy, occupational therapy services as appropriate, and those hospital services which can reasonably be provided on an ambulatory basis.

(4) Emergency services, including ambulance services and out-of-area coverage for emergency care.

(5) Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services.

(6) Home health service, which shall include, where medically appropriate, health services provided at the home of an HCO enrollee as provided or prescribed by a physician or osteopath licensed to practice in California. Such home health services shall be provided in the home, including nursing care, performed by a registered nurse, public health nurse, licensed vocational nurse or licensed home health aide.

(b) HCOs shall provide a description of the times, places and manner of providing services under the HCO, including a description of the geographical service area. The geographical service area shall be designated by a list of the postal

zip codes in the service area, and a map indicating the type and number of facilities within the service area. The following requirements must be met unless the HCO shows that a lack of a type of provider exists in an area and that the minimum number is not available:

(1) At least one full-time equivalent primary treating physician shall be available within the geographical proximity specified in paragraph (2) for every 1,200 expected injuries or illnesses. The HCO shall provide information on expected case-load and the methodology, data and assumptions used in the calculations.

(2) HCO enrollees must have a residence or workplace within 30 minutes or 15 miles of (i) a primary treating physician or (ii) a contracting or HCO-operating hospital, or if separate from such hospital, a contracting or HCO-operated provider of all emergency health care services. Enrollees must have a residence or workplace within 60 minutes or 30 miles of all other occupational health services listed in subdivision (a).

(3) The HCO must provide a description of how access to any of the basic health services listed in subdivision (a) will be provided to HCO enrollees who reside outside the HCO's geographical service area such that the requirements of this subdivision are met.

(4) Initial treatment for non-emergency services must be made available by an HCO within 24 hours of the HCO's receipt of a request for treatment.

(5) The HCO must describe how treatment is initiated and how an HCO enrollee is assigned a primary treating physician.

(6) Enrollees shall be entitled to at least one change of physician for an injury. The HCO shall provide the employee, within five days of a request by an HCO enrollee, with a choice of any other available participating provider in the appropriate specialty.

(7) HCO enrollees shall be provided with a second opinion, upon request, from a participating provider.

(8) The HCO must describe how it will make available interpreter's services, as required, for the treatment or evaluation of patients.

(9) The HCO must describe how the HCO will treat an injury or illness pending a claims administrator's decision concerning liability for treatment.

(10) HCOs must maintain and make available or insure that their contracted medical providers maintain and make available medical records to treating or evaluating physicians in a timely manner.

(c) The HCO shall describe its process for coordinating all aspects of medical treatment, including the coordination and monitoring of referrals to consultants, therapeutic or diagnostic facilities, reporting of treatment, being responsive to the HCO patient's request for change of physician or physician referrals as may be required by this article, and for ensuring timeliness of referrals and timely response to the primary treating physician.

(d) The HCO must include at least one full-time equivalent board-certified occupational medicine employed or contracting physician to provide expertise on workplace health and safety issues and prevention and treatment of occupational injuries and illnesses. The HCO shall describe its ongoing educational program to ensure that all primary treating physicians receive education, training or experience in occupational medicine and workers compensation, including but not limited to, the following:

(1) The regulatory requirements for primary treating physicians in workers' compensation;

(2) Familiarity with workplace hazards, causes of workplace injury, work restrictions, and vocational rehabilitation;

(3) The requirements of medical-legal reports in workers compensation,

NOTE: Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code. Reference: Sections 3209.3, 4600 and 4600.5, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9773.1. Referrals to Chiropractors.

HCOs shall maintain guidelines for chiropractor care in accordance with paragraph (2) of subdivision (1) of Section 4600.5 of the Labor Code. The HCO must include a description of the HCO's guidelines and utilization review process for chiropractic care, including the HCO's definition of "neuromusculoskeletal condition", and the procedure whereby enrollees may be referred to chiropractors in accordance with the HCO's guidelines.

NOTE: Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code. Reference: Section 3209.3, 4600 and 4600.5, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9774. Quality of Care.

(a) An HCO must include a written program designed to ensure a level of care for occupational injuries and illnesses which meets professionally recognized standards of care. The program must be designed and directed by providers to document that the quality of care provided is reviewed, that problems are identified, that effective action is taken to improve care where deficiencies are identified, that follow-up measures are planned where indicated, and that all of the requirements of this division are met. The plans must describe the goals and objectives of the program and organizational arrangements, including staffing, the methodology for on-going monitoring and evaluation of health services, the scope of the program, and required levels of activity. Quality of care problems must be identified and corrected. The program must demonstrate that the HCO's utilization review activities are designed to improve the quality of care provided.

The HCO shall describe and implement a program, including the following:

(1) A description of the process whereby the medical reasonableness or medical necessity of requests for authorization are reviewed and decisions on such requests are made by the HCO. The description shall include the specific criteria utilized in the review and throughout the decision-making process, including treatment protocols or standards in any software, database, or other resource used in the process. Treatment protocols must be consistent with any guidelines adopted pursuant to paragraph (8) of subdivision (e) of Section 139 of the Labor Code.

(2) A description of the qualifications of the personnel involved in reviewing and making decisions concerning requests for authorization, including the professional qualifications of the personnel, and the manner in which such personnel are involved in the review process. Medical decisions must be rendered by physicians with licenses unrestricted by their licensing board.

(3) A description of manual and automated data storage and retrieval systems for medical and utilization review; and the types of data analyses, reports, and manner in which results are communicated to providers.

(b) The HCO's quality assurance committee shall meet on at least a quarterly basis or more frequently if problems have been identified, to oversee its quality assurance program responsibilities. Reports to the HCO's governing body shall be sufficiently detailed to include findings and actions taken as a result of the quality assurance program and to identify those internal or contracting provider components which the quality assurance program had identified as presenting significant or chronic quality of care issues.

(c) The HCO is responsible for establishing a quality assurance program to monitor and evaluate the care provided by each contracting provider group or facility. Medical groups or other provider entities may have active quality assurance programs which the HCO may use. However, the HCO must retain responsibility for reviewing the overall

quality of care delivered to HCO enrollees. To the extent that the HCO's quality assurance responsibilities are delegated within the HCO or to a contracting provider or facility, the HCO shall provide evidence of an oversight mechanism for ensuring that delegated quality assurance functions are adequately performed.

(d) Physicians must be an integral part of the quality assurance program. Design and implementation of the quality assurance program shall be supervised by designated physicians. Physician participation in quality assurance activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. Specialist providers must also be involved in peer review of like specialties.

(e) The HCO may delegate inpatient quality assurance functions to hospitals, however in such case a HCO must fully describe and monitor that hospital's quality assurance program.

(f) The HCO must insure that all comprehensive medical-legal reports are prepared in an objective, fair, and unbiased manner, and that such reports are prepared in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606. The HCO or physician shall retain, for no less than three years, copies of all comprehensive medical evaluation reports which are prepared by any of its physicians to determine an employee's eligibility for compensation. These reports shall be made available to the administrative director upon request. The administrative director may review such reports as he or she deems necesary to insure compliance with this subdivision, and the results of this review may be used to deny recertification if it is determined that a significant number of an HCO's reports show bias or are legally inadequate.

(g) The HCO must describe how it will assess its activities as required by Sections 9776 and 9776.1 and the HCO's system for assuring data quality.

NOTE: Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600, 4600.5 and 4628, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9775. Grievance and Dispute Resolution Procedure.

(a) HCOs must maintain a grievance procedure under which HCO enrollees or participating providers may submit grievances to the HCO. Each HCO must include a system for resolving disputes which shall include HCO enrollee disputes with a provider and a provider's dispute with the HCO. The HCO must provide that either an HCO enrollee or a provider shall be able to initiate a grievance. Each HCO must provide reasonable procedures which insure adequate consideration of enrollee and provider grievances or disputes and which provide prompt rectification when appropriate.

(b) Compliant forms and a copy of the grievance procedure shall be readily available through each provider facility and through the claims administrator, and shall be furnished promptly upon receipt of a verbal or written request.

(c) If a grievance or dispute concerns the medical reasonableness or medical necessity of treatment recommended by a provider, the HCO must provide for an expedited procedure for review of the grievance or dispute by physicians or qualified professional providers not previously involved in the grievance or dispute and who possess the specialty which is appropriate to the medical nature of the disputed treatment. Under no circumstance may the appeal decision be made by a registered nurse. The HCO must issue a written decision as to the grievance or dispute within 30 days unless the HCO enrollee's medical condition requires a more expedited decision.

(d) Each HCO shall inform providers and HCO enrollees, or their representatives, that they may file a written complaint to the administrative director

(e) The HCO shall annually provide to the administrative director a summary of written grievances received concerning the provision of occupational health services, including the number of total grievances received and processed. Records of all written grievances concerning the provision of occupational health services, including the name of the grievant, the nature of the complaint or grievance, and the manner in which the grievance was resolved or referred for further action, shall be kept by the HCO for a period of not less than 3 years and shall be made available by the HCO to the administrative director as he or she deems necessary.

NOTE: Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600 and 4600.5, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9776. Workplace Safety and Health.

(a) The HCO must maintain the capability to work cooperatively and in conjunction with claims administrators, employers, and employees to promote workplace health and safety and to detect workplace exposures and hazards, including:

(1) education of employees and employers on health and medical aspects of workplace health and safety issues;

(2) consultation on employee medical screening for early detection of occupational disease, and assessment of workplace risk factors.

(b) An HCO shall include in contracts with claims administrators a provision which enables the HCO to obtain upon request information to allow appropriate provider decision-making regarding diagnoses, patient medical restrictions, early disease detection, or return-to-work, which may include:

(1) the employer's written Injury and Illness Prevention Plan, including the name and title of individual responsible for implementing the plan.

(2) information concerning exposure levels for specified materials, and information, including Material Safety Data Sheets, concerning health, safety, and ergonomic risk factors in the workplace.

(3) the name and title of the individual responsible for loss control services for each employer.

(c) The HCO shall have in place a program for prompt reporting, to the employer or insurer loss control program and to the employer's designee responsible for the Injury and Illness Prevention Plan, of the following occupational injuries and illnesses: occupational asthma; cumulative trauma disorders of the upper extremities; lead poisoning; amputations (excluding amputations of the distal phalanges); noise-induced hearing loss; pesticide illness; electrocutions; asphyxiation; and burns and falls from heights requiring hospitalization.

(d) The HCO shall annually report to the insurer loss control program or to the employer's designee responsible for the Injury and Illness Prevention Plan as designated in the contract between the HCO and the claims administrator, aggregate data on injuries and illnesses.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9776.1. Return to Work Coordination.

An HCO shall maintain a return to work program in conjunction with the employer and claims administrator to facilitate and coordinate returning injured workers to the workplace, to assess the feasibility and availability of modified work or modified duty, and to minimize risk of employee exposure after return to work to risk factors which may aggravate or cause recurrence of injury. The duties of the HCO shall be specified in the contract between the HCO and the claims administrator.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9777. Patient Assistance and Notification.

(a) The HCO shall inform HCO enrollees upon enrollment in the plan and annually thereafter of the details of their coverage, and their rights and options under the HCO including: (1) how HCO enrollees are informed of the procedure for processing and resolving grievances, including the location(s) and telephone number where grievances may be submitted; and (2) how HCO enrollees are informed of their right to file a complaint with the administrative director in accordance with subdivision (d) of Section 9775.

(b) The HCO shall provide patient education specifically designed for injured workers with work-related injuries or illnesses.

(c) HCO enrollees must be able to receive information on a 24-hour basis regarding the availability of necessary medical services available within the HCO. The information may be provided through recorded telephone message after normal working hours. It must include information on how the enrollee can obtain emergency services or other urgently needed care and how the employee can access an evaluation within 24 hours of the injury as required under paragraph 4 of subdivision (b) of section 9773.

(d) Informational materials must be in a form understandable to all enrollees and available in Spanish. HCOs must provide in their application a description of how the information specified in subdivisions (a) through (c) will be provided to HCO enrollees. A copy of the informational material provided to HCO enrollees, including the text of phone messages, shall be made available to the administrative director upon request.

(e) The HCO shall provide for periodic evaluation of the HCO by enrollees. The HCO must provide a survey to HCO enrollees and patients, which shall be in the form and manner prescribed by the administrative director. The HCO must describe its method for incorporating the results of the survey in its quality assurance program. The completed forms and any data extracted from such forms shall be made available to the administrative director upon request.

NOTE: Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600 and 4600.5, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9778. Evaluation.

(a) The HCO must include a timely and accurate method to report to the administrative director the following information, in a standardized format to be prescribed by the administrative director:

(1) Aggregated information on the number of HCO enrollees and their age, sex, geographical distribution, occupation, and SIC, by federal employer identification number.

(2) Information required to be provided pursuant to this section shall be made available by the HCO to the administrative director, in a form and manner to be prescribed by the administrative director, annually, on March 1.

(b) Information regarding medical and health care service cost and utilization, rates of return to work, and average time in medical treatment shall be submitted by the claims administrator in the format specified in Article 1.1 (commencing with section 9700).

Note: Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600 and 4600.5, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

2. New subsections (c)-(c)(2) filed 10-7-99; operative 3-1-2000 (Register 99, No. 41).

3. Amendment filed 11-4-2009; operative 1-1-2010 (Register 2009, No. 45).

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§9779. Certification.

(a) Once an applicant has completed an application and submitted a fee in accordance with Section 9771 and has demonstrated to the administrative director that its organization has met all of the criteria for certification, the administrative director will certify the organization as an HCO for a period of three years, unless earlier revoked or suspended.

(b) Once the Administrative Director has determined that an entity licensed as a full service health care service plan under Section 1353 of the Health and Safety Code (a Knox-Keene Health Care Service Plan Act) and deemed to be an HCO pursuant to Labor Code Section 4600.5(c) has complied with the requirements of Section 9771 subsections (g)(1) and (2) the administrative director shall certify the organization as an HCO, pursuant to Section 4600.5(c), for a period of three years unless earlier revoked or suspended.

(c) A certification shall state that a particular entity is certified as a health care organization to provide health care to injured employees for injuries and diseases and other services in accordance with the terms of the entity's application. The certification shall also state: (1) the geographic service area in which the health care organization is permitted to provide health care, (2) the maximum number of enrollees, (3) the name or names under which the health care organization is permitted to provide health care, (4) the date of expiration of the certification, and (5) any other conditions or limitations.

(d) The HCO will be recertified at the expiration of each subsequent three year period, provided it continues to meet the requirements of this article and timely pays a recertification fee of $1,000.

Note: Authority cited: Sections 133, 4600.5, 4600.7, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600, 4600.5 and 4600.7, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

2. Amendment of subsection (a), repealer and new subsection (b), amendment of subsection (c), repealer and new subsection (d), repealer of subsection (e), and amendment of Notefiled 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No.

7).

3. New subsection (b), repealer of subsection (d) and subsection relettering filed 1-9-2003; operative 1-9-2003 pursuant to Government Code section11343.4 (Register 2003, No. 2).

4. Amendment of subsection (d) filed 11-4-2009; operative 1-1-2010 (Register 2009, No. 45).

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§9779.1. On-Site Surveys.

(a) The HCO must ensure that it will be available for and cooperate with on-site surveys as the administrative director deems necessary to insure compliance with this article, including during the initial certification process. The administrative director will coordinate on-site surveys with the Department of Managed Health Care to the extent feasible.

(b) The administrative director will notify the HCO of deficiencies found by the survey team. The administrative director will provide the HCO a reasonable time to correct the deficiencies. Failure on the part of the HCO to timely correct noted deficiencies may result in suspension or revocation of an HCO's certification in accordance with Section 9779.2.

(c) Reports of all surveys shall be open to public inspection, except that no survey shall be made public unless the HCO has had an opportunity to review the survey and file a statement in response within 30 days, to be attached to the report. Deficiencies shall not be made public if they are corrected within 30 days of the date that the HCO was notified.

(d) Non-routine audits will be charged based on the actual cost for performing the audit. The amount shall include the actual salaries or compensation paid to the persons making the audit, the expenses incurred in the course thereof, and overhead costs in connection therewith as fixed by the Administrative Director. Overhead costs shall be based on the total expenditure for operating expenses and equipment, except travel, of the managed care unit of the Division of Workers' Compensation for the previous fiscal year. The invoice will be sent upon the completion of the audit and shall be paid within 30 calendar days.

NOTE

Authority cited: Sections 133, 4600.5, 4600.7, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600, 4600.5 and 4600.7, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

2. Editorial correction of section heading (Register 96, No. 7).

3. New subsection (d) and amendment of Note filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

4. Amendment of subsection (a) filed 1-9-2003; operative 1-9-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 2).

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§9779.2. Suspension; Revocation; Hearing.

(a) Complaints pertaining to an HCO's violations of this article may be directed in writing to the administrative director. Upon receipt of a complaint, or in the course of monitoring the HCO's operations, the administrative director may investigate an alleged violation. The investigation may include, but not be limited to, a request for and review of pertinent HCO records, interviewing medical and administrative personnel, or an on-site medical survey. If the investigation reveals reasonable cause to belive that the HCO has violated a requirement of this article, the administrative director may initiate proceedings to suspend or revoke an HCO's certification.

(b) Certification of an HCO may be suspended or revoked if:

(1) Service under the HCO is not being provided according to the terms of the certified HCO.

(2) The HCO fails to meet the requirements of this article, the Labor Code, or other applicable law.

(3) False or misleading information is knowingly or repeatedly submitted by the HCO or a participating provider or the HCO knowingly or repeatedly fails to report information required by this article.

(4) The HCO knowingly continues to use the services of a provider or medical reviewer whose license, registration, or certification has been suspended or revoked or who is otherwise ineligible to provide treatment to an inured worker under California law.

(c) In the event an HCO or organization is formally notified of the administrative director's intention to revoke or suspend the HCO's certification, or to refuse certification or recertification as an HCO, the HCO or organization shall be entitled to a hearing before the administrative director or an administrative law judge which shall be shall be held in accordance with the Administrative Procedure Act {Chapter 5 (commencing with Section 11500), of Part 1 of Division 3 of Title 2 of the Government Code}, and the administrative director shall have all of the powers granted under that act.

NOTE: Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600 and 4600.5, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9779.3. Obligations of Employer Covered by a Contract with a Health Care Organization

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(a) When an insurer or employers, a group of self-insured employers, or self-insured employers have contracted with a health care organization certified pursuant to Section 4600.5 of the Labor Code the employer shall provide information to all employees who are eligible to be enrolled in the health care organization as follows:

(1) a new employee shall be provided with the choice of enrolling in an HCO or designating the employee's own personal physician or personal chiropractor no later than 30 days following the employee's date of hire.

(2) a current employee shall be provided with the choice of enrolling in an HCO or designating the employee's own personal physician or personal chiropractor no later than 30 days before the initial enrollment period ends;

(3) an employer must provide information concerning the HCO it is offering to its employees no later than 30 days prior to the final date for enrollment. Information shall be provided in written form, in no less than twelve (12) point typeface, and in a language understandable to employees. The information provided must include, at a minimum, the following:

(i) the name of the HCO offered;

(ii) the corporate or business name of all entities which own or control the HCO offered; and indication of relationship, if any, of the HCO to workers' compensation carrier or self-insured employer;

(iii) the services offered by the HCO;

(iv) a complete listing of all primary treating physicians, specialist physicians, and clinics participating in the HCO who would be reasonably accessible to the employee for the provision of occupational health services. Primary treating physicians who are not accepting new patients must be clearly identified;

(v) If the HCO is also the provider of group health coverage for non-occupational health services, the HCO policy regarding enrollees' ability to use their personal physician (for non-occupational health services) for treatment of work injuries.

(vi) any provider risk-sharing arrangements related to utilization of services.

(4) Within fifteen days following enrollment, the HCO must provide to each enrollee complete information regarding HCO services and processes, including but not limited to:

(i) the services offered, including interpreters services, how such services are obtained, hours of services;

(ii) the definition of emergency care, how to obtain out-of-service treatment, how to obtain after-hours services;

(iii) case management and medical management processes, selection of the primary treating physician, and method for obtaining second opinions, change of physician, or referrals to chiropractors, physical therapists, or specialists;

(iv) the grievance and dispute resolution procedures;

(v) additional services offered, including return to work, health and safety, patient assistance, and patient education.

(b) Employees shall designate their enrollment option on form DWC 1194. This form must be maintained in the employee's personnel file for a minimum of three (3) years, and be made available to the employee or employee's representative on request.

Employees who designate on form DWC 1194 that they do not wish to enroll in an HCO and wish to pre-designate their own personal physician or personal chiropractor or personal acupuncturist shall pre-designate that personal physician or personal chiropractor or personal acupuncturist on the form 1194. At least once each year the employer shall provide the employee with a notice informing the employee of his or her right to continue as an enrollee of the HCO, change to another HCO if another HCO is offered by the employer, or designate the employee's own personal physician, personal chiropractor or personal acupuncturist instead of the HCO. If another HCO is offered by the employer and the employee chooses to change to another HCO, or if the employee chooses to designate a personal physician, personal chiropractor or personal acupuncturist, the employee shall designate such choice on a form DWC 1194, which shall be provided by the employer.

NOTE

Authority cited: Sections 133, 4600.3, 4600.5, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600, 4600.3 and 4600.5, Labor Code.

HISTORY

1. New section filed 3-27-95; operative 3-27-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 13).

2. Amendment filed 5-17-99; operative 5-17-99 pursuant to Government Code section 11343.4(d) (Register 99, No. 21).

3. Amendment of section heading and section filed 1-9-2003; operative 1-9-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 2).

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§9779.4. DWC Form 1194.

DWC Form 1194, Choosing Medical Care for Work-Related Injuries and Illnesses (.pdf format, 16K)

NOTE

Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600 and 4600.5, Labor Code.

HISTORY

1. New section filed 3-27-95; operative 3-27-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 13).

2. Amendment filed 1-9-2003; operative 1-9-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 2).

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§9779.45. Minimum Periods of Enrollment.

Pursuant to Labor Code Section 4600.3:

(a) An employee whose employer does not offer non-occupational health coverage under a plan established pursuant to collective bargaining, and does not offer to pay more than one-half the cost of non-occupational health coverage for that employee under another plan, may be treated for occupational injuries and illnesses by a physician of the employee's choosing after 90 days from the date the injury was reported.

(b) An employee whose employer offers non-occupational health coverage under a plan established pursuant to collective bargaining, or offers to pay more than one-half the cost of non-occupational health coverage for that employee under another plan, may be treated for occupational injuries and illnesses by a physician of the employee's choosing after 180 days from the date the injury was reported or upon the date of contract renewal or open enrollment of the health care organization, whichever occurs first, but in no case until 90 days from the date the injury was reported.

NOTE

Authority cited: Sections 133, 4600.3, 4600.5, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600, 4600.3 and 4600.5, Labor Code.

HISTORY

1. New section filed 5-17-99; operative 5-17-99 pursuant to Government Code section 11343.4(d) (Register 99, No. 21).

2. Repealer of subsection (c) filed 1-9-2003; operative 1-9-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 2).

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§9779.5 Reimbursement of Costs to the Administrative Director; Obligation to Pay Share of Administrative Expense.

(a) Each organization certified under this article shall pay to the administrative director an amount as estimated by the administrative director for the ensuing fiscal year, as a reimbursement of a share of all costs and expenses, including routine on-site surveys, data collection and dissemination and overhead, reasonably incurred in the administration of this article and not otherwise recovered by the administrative director under this article or from the Worker's Compensation Managed Care Fund. The amount shall be assessed annually on or before April 15 and may be paid to the Workers' Compensation Managed Care Fund in two equal installments. The first installment shall be paid on or before July 1 of each year and the second installment shall be paid on or before December 15 of each year.

(1) Annual Assessment: The assessment shall be calculated on the basis of the number of enrollees in each individual HCO. Based on the number of enrollees enrolled in the HCO on December 31 of the prior calendar year, the annual assessment shall be $250.00 for 0 to 1000 enrollees, $350 for 1001 to 5000 enrollees, and $500 for 5001 or more enrollees.

(b) Non-routine audits conducted in response to complaints will be charged based on the actual cost for performing the audit. The invoice will be sent within sixty days of the completion of the audit and shall be paid within 30 calendar days after the billing date.

(c) In no case shall the reimbursement, payment, or other fee authorized by this section exceed the cost, including overhead, reasonably incurred in the administration of this article.

Note: Authority cited: Sections 133, 4600.5, 4600.7, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600 and 4600.5, Labor Code.

HISTORY

1. New section filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

2. Amendment of subsection (a)(1) and repealer and new subsection (a)(2) filed 5-17-99; operative 5-17-99 pursuant to Government Code section11343.4(d) (Register 99, No. 21).

3. Amendment of subsection (a)(1) and repealer of subsection (a)(2) filed 11-4-2009; operative 1-1-2010 (Register 2009, No. 45).

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Article 4. Certification Standards for Health Care Organizations

New query

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§9779.8 Copies of Documents.

Fees for copies of documents will be charged as set forth in Section 9990. Any request for copies of documents must include payment of fees by check or money order made payable to the Workers' Compensation Managed Care Fund.

NOTE: Authority: Sections 133, 4600.5, 4600.7, 4603.5, 5307.3, Labor Code. Reference: Sections 4600, 4600.5, Labor Code.

HISTORY

1. New section filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

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New query

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§9779.9 Late Payment. [Repealed]

Note: Authority: Sections 133, 4600.5, 4600.7, 4603.5, 5307.3, Labor Code. Reference: Sections 4600, 4600.5, Labor Code.

HISTORY

1. New section filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

2. Repealer filed 11-4-2009; operative 1-1-2010 (Register 2009, No. 45).

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Chapter 4.5. Division of Workers' Compensation

Subchapter 1. Administrative Director--Administrative Rules

Article 5. Predesignation of Personal Physician; Request for Change of Physician; Reporting Duties of the Primary Treating Physician; Petition for Change of Primary Treating Physician

New query

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§9780. Definitions.

As used in this Article:

(a) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, a self-administered joint powers authority, a self-administered legally uninsured, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(b) "Emergency health care services" means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

(c) "Facility" means a hospital, clinic or other institution capable of providing the medical, surgical, chiropractic or hospital treatment which is reasonably required to cure or relieve the employee from the effects of the injury.

(d) "First aid" is any one-time treatment, and a follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, etc., which do not ordinarily require medical care. Such one-time treatment, and follow-up visit for the purpose of observation, is considered first aid, even though provided by a physician or registered professional personnel.

(e) "Nonoccupational group health coverage" means coverage for nonoccupational health care that the employer makes available to the employee, including, but not limited to, a Taft Hartley or Employee Retirement Income Security Act (ERISA) trust, or a health plan negotiated between a union or employee's association and the employer or employer's association.

(f)(1) "Personal Physician" means the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with section 2000) of Division 2 of the Business and Professions Code, (2) who has been the employee's primary care physician, and has previously directed the medical treatment of the employee, and (3) who retains the employee's medical records, including the employee's medical history.

(g) "Primary Care Physician" means a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. A primary care physician shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner.

(h) "Reasonable geographic area" within the context of Labor Code section 4600 shall be determined by giving consideration to:

(1) The employee's place of residence, place of employment and place where the injury occurred; and

(2) The availability of physicians in the fields of practice, and facilities offering treatment reasonably required to cure or relieve the employee from the effects of the injury;

(3) The employee's medical history;

(4) The employee's primary language.

Note: Authority cited: Sections 59, 133 and 4603.5, Labor Code. Reference: Section 4600, Labor Code.

HISTORY

1. Repealer of Article 5 (Sections 9783-9785, 9787 and 9788) and new Article 5 (Sections 9780-9787) filed 1-28-76 as an emergency; effective upon filing (Register 76, No. 5). For prior history, see Register 70, No. 49, and Register 72, No. 51.

2. Certificate of Compliance filed 1-29-76 (Register 76, No. 5).

3. New subsections (f)-(i) filed 11-7-78; effective thirtieth day thereafter (Register 78, No. 45).

4. Repealer and new article 5 heading and amendment of section and Note filed 3-14-2006; operative 3-14-2006 pursuant to Government Code section 11343.4 (Register 2006, No. 11).

5. Editorial correction of subsection (f)(1) (Register 2007, No. 7).

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New query

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§9780.1. Employee's Predesignation of Personal Physician.

(a) An employee may be treated for an industrial injury in accordance with section 4600 of the Labor Code by a personal physician that the employee predesignates prior to the industrial injury if the following three conditions are met:

(1) Notice of the predesignation of a personal physician is in writing, and is provided to the employer prior to the industrial injury for which treatment by the personal physician is sought. The notice shall include the personal physician's name and business address. The employee may use the optional predesignation form (DWC Form 9783) in section 9783 for this purpose.

(2) The employer provides: (i) nonoccupational group health coverage in a health care service plan, licensed pursuant to Chapter 2.2 (commencing with section 1340) of Division 2 of the Health and Safety Code, or (ii) nonoccupational health coverage in a group health plan or a group health insurance policy as described in section 4616.7 of the Labor Code. The employer's provision of health coverage as defined herein is sufficient to meet this requirement, regardless of whether the employee accepts or participates in this health coverage.

(3) The employee's personal physician agrees to be predesignated prior to the injury. The personal physician may sign the optional predesignation form (DWC Form 9783) in section 9783 as documentation of such agreement. The physician may authorize a designated employee of the physician to sign the optional predesignation form on his or her behalf. If the personal physician or the designated employee of the physician does not sign a predesignation form, there must be other documentation that the physician agrees to be predesignated prior to the injury in order to satisfy this requirement.

(b) If an employee has predesignated a personal physician prior to the effective date of these regulations, such predesignation shall be considered valid if the conditions in subdivision (a) have been met.

(c) Where an employer or an employer's insurer has a Medical Provider Network pursuant to section 4616 of the Labor Code, an employee's predesignation which has been made in accordance with this section shall be valid and the employee shall not be subject to the Medical Provider Network.

(d) Where an employee has made a valid predesignation pursuant to this section, and where the employer or employer's insurer has a Medical Provider Network, any referral to another physician for other treatment need not be within the Medical Provider Network.

(e) An employer who qualifies under (a)(2) of this section shall notify its employees of all of the requirements of this

section and provide its employees with an optional form for predesignating a personal physician, in accordance with section 9880. The employer may use the predesignation form (DWC Form 9783) in section 9783 for this purpose.

(f) Unless the employee agrees, neither the employer nor the claims administrator shall contact the predesignated personal physician to confirm predesignation status or contact the personal physician regarding the employee's medical information or medical history prior to the personal physician's commencement of treatment for an industrial injury.

(g) Where the employer has been notified of an employee's predesignation of a personal physician in accordance with this section and where the employer becomes liable for an employee's medical treatment, the claims administrator shall:

(1) authorize the predesignated physician to provide all medical treatment reasonably required to cure or relieve the injured employee from the effects of his or her injury;

(2) furnish the name and address of the person to whom billing for treatment should be sent;

(3) where there has been treatment of an injury prior to commencement of treatment by the predesignated physician, arrange for the delivery to the predesignated physician of all medical information relating to the claim, all X-rays, the results of all laboratory studies done in relation to the injured employee's treatment; and

(4) provide the physician with (1) the fax number, if available, to be used to request authorization of treatment plans; (2) the complete requirements of section 9785; and (3) the forms set forth in sections 9785.2 and 9785.4. In lieu of providing the materials required in (2) and (3) immediately above, the claims administrator may refer the physician to the Division of Workers' Compensation's website where the applicable information and forms can be found at http://www.dir.ca.gov/DWC/dwc_home_page.htm.

(h) Notwithstanding subdivision (g), the employer shall provide first aid and appropriate emergency health care services reasonably required by the nature of the injury or illness. Thereafter, if further medical treatment is reasonably required to cure or relieve the injured employee from the effects of his or her injury, the claims administrator shall authorize treatment with the employee's predesignated personal physician in accordance with subdivision (g).

(i) If documentation of a physician's agreement to be predesignated has not been provided to the employer as of the time of injury, treatment shall be provided in accordance with Labor Code section 4600, or Labor Code section 4616, if the employer or insurer has established a Medical Provider Network, as though no predesignation had occurred. Upon provision of the documented agreement that was made prior to injury that meets the conditions of Labor Code section 4600(d), the employer or claims administrator shall authorize treatment with the employee's predesignated physician as set forth in subdivision (g).

Note: Authority cited: Sections 59, 133 and 4603.5, Labor Code. Reference: Sections 3551, 4600 and 4616, Labor Code.

HISTORY

1. New section filed 11-7-78; effective thirtieth day thereafter (Register 78, No. 45).

2. Amendment of section heading, repealer and new section and amendment of Note filed 3-14-2006; operative 3-14-2006 pursuant to Government Code section11343.4 (Register 2006, No. 11). 8 CA ADC s 9780.1

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New query

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§9780.2. Employer's Duty to Provide First Aid and Emergency Treatment

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Note: Authority cited: Sections 124, 127, 133, 138.2, 138.3, 138.4, 139, 139.5, 139.6, 4600, 4601, 4602, 4603, 4603.2, 4603.5, 5307.3, 5450, 5451, 5452, 5453, 5454, and 5455, Labor Code. Reference: Chapters 442, 709, and 1172, Statutes of 1977; Chapter 1017, Statutes of 1976.

HISTORY

1. New section filed 11-7-78; effective thirtieth day thereafter (Register 78, No. 45).

2. Repealer filed 3-14-2006; operative 3-14-2006 pursuant to Government Codesection 11343.4 (Register 2006, No. 11).

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New query

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§9781. Employee's Request for Change of Physician.

(a) This section shall not apply to self-insured and insured employers who offer a Medical Provider Network pursuant to section 4616 of the Labor Code.

(b) Pursuant to section 4601 of the Labor Code, and notwithstanding the 30 day time period specified in subdivision (c), the employee may request a one time change of physician at any time.

(1) An employee's request for change of physician pursuant to this subdivision need not be in writing. The claims administrator shall respond to the employee in the manner best calculated to inform the employee, and in no event later than 5 working days from receipt of said request, the claims administrator shall provide the employee an alternative physician, or if the employee so requests, a chiropractor or acupuncturist.

(2) Notwithstanding subdivision (a) of section 9780.1, if an employee requesting a change of physician pursuant to this subdivision has notified his or her employer in writing prior to the date of injury that he or she has either a personal chiropractor or a personal acupuncturist, and where the employee so requests, the alternative physician tendered by the claims administrator to the employee shall be the employee's personal chiropractor or personal acupuncturist as defined in subdivisions (b) and (c), respectively, of Labor Code section 4601. The notification to the employer must include the name and business address of the chiropractor or acupuncturist. The employer shall notify its employees of the requirements of this subdivision and provide its employees with an optional form for notification of a personal chiropractor or acupuncturist, in accordance with section 9880. DWC Form 9783.1 in section 9783.1 may be used for this purpose.

(3) Except where the employee is permitted to select a personal chiropractor or acupuncturist as defined in subdivisions (b) and (c), respectively, of Labor Code section 4601, the claims administrator shall advise the employee of the name and address of the alternative physician, or chiropractor or acupuncturist if requested, the date and time of an initial scheduled appointment, and any other pertinent information.

(c) Pursuant to section 4600, after 30 days from the date the injury is reported, the employee shall have the right to be treated by a physician or at a facility of his or her own choice within a reasonable geographic area.

(1) The employee shall notify the claims administrator of the name and address of the physician or facility selected pursuant to this subdivision. However, this notice requirement will be deemed to be satisfied if the selected physician or facility gives notice to the claims administrator of the commencement of treatment or if the claims administrator receives this information promptly from any source.

(2) If so requested by the selected physician or facility, the employee shall sign a release permitting the selected physician or facility to report to the claims administrator as required by section 9785.

(d) When the claims administrator is notified of the name and address of an employee-selected physician or facility pursuant to subdivision (c), or of a personal chiropractor or acupuncturist pursuant to paragraph (2) of subdivision (b), the claims administrator shall:

(1) authorize such physician or facility or personal chiropractor or acupuncturist to provide all medical treatment reasonably required pursuant to section 4600 of the Labor Code;

(2) furnish the name and address of the person to whom billing for treatment should be sent;

(3) arrange for the delivery to the selected physician or facility of all medical information relating to the claim, all X-rays and the results of all laboratory studies done in relation to the injured employee's treatment; and

(4) provide the physician or facility with (1) the fax number, if available, to be used to request authorization of treatment plans; (2) the complete requirements of section 9785; and (3) the forms set forth in sections 9785.2 and 9785.4. In lieu of providing the materials required in (2) and (3) immediately above, the claims administrator may refer the physician or facility to the Division of Workers' Compensation's website where the applicable information and forms can be found at http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Note: Authority cited: Sections 133 and 4603.5, Labor Code. Reference: Sections 3551, 4600 and 4601, Labor Code.

HISTORY

1. Repealer and new section filed 11-9-77; effective thirtieth day thereafter (Register 77, No. 46).

2. Repealer and new section and amendment ofNote filed 3-14-2006; operative 3-14-2006 pursuant to Government Code section 11343.4 (Register 2006, No.11).

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New query

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§9782. Notice to Employee of Right to Choose Physician.

(a) Except for an employer who has established a Medical Provider Network, or an employer whose insurer has established a Medical Provider Network, every employer shall advise its employees in writing of an employee's right (1) to request a change of treating physician if the original treating physician is selected initially by the employer pursuant to Labor Code section 4601, and (2) to be treated by a physician of his or her own choice 30 days after reporting an injury pursuant to subdivision (c) of Labor Code 4600.

(b) Every employer shall advise its employees in writing of an employee's right to predesignate a personal physician pursuant to subdivision (d) of Labor Code section 4600, and section 9780.1.

(c) The notices required by this section shall be provided in accordance with section 9880 and posted in accordance with section 9881.

Note: Authority cited: Sections 133 and 4603.5, Labor Code. Reference: Sections 3550, 3551, 4600, 4601 and 4616, Labor Code.

HISTORY

1. Repealer and new section filed 11-9-77; effective thirtieth day thereafter (Register 77, No. 46).

2. Repealer and new section filed 11-7-78; effective thirtieth day thereafter (Register 78, No. 45).

3. Amendment of section andNote filed 3-14-2006; operative 3-14-2006 pursuant to Government Code section 11343.4 (Register 2006, No. 11).

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New query

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§9783. DWC Form 9783 Predesignation of Personal Physician.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.) or doctor of osteopathic medicine (D.O.) if:
your employer offers group health coverage;
the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
prior to the injury your doctor agrees to treat you for work injuries or illnesses;
prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address. You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.
To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by:
_____ (name of doctor)(M.D., D.O.)
_____ _____(street address, city, state, ZIP)
_____(telephone number)
Employee Name (please print): _____ _____
Employee's Address: _____
Employee's Signature _____ Date: _____
Physician: I agree to this Predesignation:
Signature: _____ Date: _____
(Physician or Designated Employee of the Physician)

The physician is not required to sign this form, however, if the physician or designated employee of the physician does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).
Title 8, California Code of Regulations, section 9783. (Optional DWC Form 9783 - Effective date March 2006)

Note: Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Section 4600, Labor Code

HISTORY

1. Amendment filed 11-11-78; effective thirtieth day thereafter (Register 78, No. 45).

2. Repealer and new section heading, section and Note filed 3-14-2006; operative 3-14-2006 pursuant to Government Code section 11343.4 (Register 2006, No. 11).

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New query

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§9784. Duties of the Employer.

Note: Authority cited: Sections 124, 127, 133, 138.2, 138.3, 138.4, 139, 139.5, 139.6, 4600, 4601, 4602, 4603, 4603.2, 4603.5, 5307.3, 5450, 5451, 5452, 5453, 5454, and 5455, Labor Code. Reference: Chapters 442, 709, and 1172, Statutes of 1977; Chapter 1017, Statutes of 1976.

HISTORY

1. Repealer and new section filed 11-9-77; effective thirtieth day thereafter (Register 77, No. 46).

2. Amendment filed 11-11-78; effective thirtieth day thereafter (Register 78, No. 45).

3. Repealer filed 3-14-2006; operative 3-14-2006 pursuant to Government Codesection 11343.4 (Register 2006, No. 11).

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Chapter 4.5. Division of Workers' Compensation
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Article 5. Transfer of Medical Treatment

New query

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§9785. Reporting Duties of the Primary Treating Physician.

(a) For the purposes of this section, the following definitions apply:

(1) The “primary treating physician” is the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. The primary treating physician is the physician selected by the employer, the employee pursuant to Article 2 (commencing with section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code, or under the contract or procedures applicable to a Health Care Organization certified under section 4600.5 of the Labor Code, or in accordance with the physician selection procedures contained in the medical provider network pursuant to Labor Code section 4616.

(2) A “secondary physician” is any physician other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee.

(3) “Claims administrator” is a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(4) “Medical determination” means, for the purpose of this section, a decision made by the primary treating physician regarding any and all medical issues necessary to determine the employee's eligibility for compensation. Such issues include but are not limited to the scope and extent of an employee's continuing medical treatment, the decision whether to release the employee from care, the point in time at which the employee has reached permanent and stationary status, and the necessity for future medical treatment.

(5) “Released from care” means a determination by the primary treating physician that the employee's condition has reached a permanent and stationary status with no need for continuing or future medical treatment.

(6) “Continuing medical treatment” is occurring or presently planned treatment that is reasonably required to cure or relieve the employee from the effects of the injury.

(7) “Future medical treatment” is treatment which is anticipated at some time in the future and is reasonably required to cure or relieve the employee from the effects of the injury.

(8) “Permanent and stationary status” is the point when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment.

(b)(1) An employee shall have no more than one primary treating physician at a time.

(2) An employee may designate a new primary treating physician of his or her choice pursuant to Labor Code §§4600 or 4600.3 provided the primary treating physician has determined that there is a need for:

(A) continuing medical treatment; or

(B) future medical treatment. The employee may designate a new primary treating physician to render future medical treatment either prior to or at the time such treatment becomes necessary.

(3) If the employee disputes a medical determination made by the primary treating physician, including a determination that the employee should be released from care, or if the employee objects to a decision made pursuant to Labor Code section 4610 to modify, delay, or deny a treatment recommendation, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections4061 and 4062. No other primary treating physician shall be designated by the employee unless and until the dispute is resolved.

(4) If the claims administrator disputes a medical determination made by the primary treating physician, the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4610, 4061 and 4062.

(c) The primary treating physician, or a physician designated by the primary treating physician, shall make reports to the claims administrator as required in this section. A primary treating physician has fulfilled his or her reporting duties under this section by sending one copy of a required report to the claims administrator. A claims administrator may designate any person or entity to be the recipient of its copy of the required report.

(d) The primary treating physician shall render opinions on all medical issues necessary to determine the employee's eligibility for compensation in the manner prescribed in subdivisions (e), (f) and (g) of this section. The primary treating physician may transmit reports to the claims administrator by mail or FAX or by any other means satisfactory to the claims administrator, including electronic transmission.

(e)(1) Within 5 working days following initial examination, a primary treating physician shall submit a written report to the claims administrator on the form entitled “Doctor's First Report of Occupational Injury or Illness,” Form DLSR 5021. Emergency and urgent care physicians shall also submit a Form DLSR 5021 to the claims administrator following the initial visit to the treatment facility. On line 24 of the Doctor's First Report, or on the reverse side of the form, the physician shall (A) list methods, frequency, and duration of planned treatment(s), (B) specify planned consultations or referrals, surgery or hospitalization and (C) specify the type, frequency and duration of planned physical medicine services (e.g., physical therapy, manipulation, acupuncture).

(2) Each new primary treating physician shall submit a Form DLSR 5021 following the initial examination in accordance with subdivision (e)(1).

(3) Secondary physicians, physical therapists, and other health care providers to whom the employee is referred shall report to the primary treating physician in the manner required by the primary treating physician.

(4) The primary treating physician shall be responsible for obtaining all of the reports of secondary physicians and shall, unless good cause is shown, within 20 days of receipt of each report incorporate, or comment upon, the findings and opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator.

(f) A primary treating physician shall, unless good cause is shown, within 20 days report to the claims administrator when any one or more of the following occurs:

(1) The employee's condition undergoes a previously unexpected significant change;

(2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a new need for referral to or

consultation by another physician, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic devices;

(3) The employee's condition permits return to modified or regular work;

(4) The employee's condition requires him or her to leave work, or requires changes in work restrictions or modifications;

(5) The employee is released from care;

(6) The primary treating physician concludes that the employee's permanent disability precludes, or is likely to preclude, the employee from engaging in the employee's usual occupation or the occupation in which the employee was engaged at the time of the injury, as required pursuant to Labor Code Section 4636(b);

(7) The claims administrator reasonably requests appropriate additional information that is necessary to administer the claim. “Necessary” information is that which directly affects the provision of compensation benefits as defined in Labor Code Section 3207.

(8) When continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred. If an examination has occurred, the report shall be signed and transmitted within 20 days of the examination.

Except for a response to a request for information made pursuant to subdivision (f)(7), reports required under this subdivision shall be submitted on the “Primary Treating Physician's Progress Report” form (Form PR-2) contained in Section 9785.2, or in the form of a narrative report. If a narrative report is used, it must be entitled “Primary Treating Physician's Progress Report” in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2. A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-2: “I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code §139.3.”

By mutual agreement between the physician and the claims administrator, the physician may make reports in any manner and form.

(g) When the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall, unless good cause is shown, report within 20 days from the date of examination any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing and/or future medical care resulting from the injury. The information may be submitted on the “Primary Treating Physician's Permanent and Stationary Report” form (DWC Form PR-3 or DWC Form PR-4) contained in section 9785.3 or section 9785.4, or in such other manner which provides all the information required by Title 8, California Code of Regulations, section 10606. For permanent disability evaluation performed pursuant to the permanent disability evaluation schedule adopted on or after January 1, 2005, the primary treating physician's reports concerning the existence and extent of permanent impairment shall describe the impairment in accordance with the AMA Guides to the Evaluation on Permanent Impairment, 5th Edition (DWC Form PR-4). Qualified Medical Evaluators and Agreed Medical Evaluators may not use DWC Form PR-3 or DWC Form PR-4 to report medical-legal evaluations.

(h) Any controversies concerning this section shall be resolved pursuant to Labor Code Section 4603 or 4604, whichever is appropriate.

(i) Claims administrators shall reimburse primary treating physicians for their reports submitted pursuant to this section as required by the Official Medical Fee Schedule.

NOTE

Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 4061, 4061.5, 4062, 4600, 4600.3, 4603.2, 4636, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. Amendment filed 11-9-77; effective thirtieth day thereafter (Register 77, No. 46).

2. Amendment of subsection (b) filed 11-11-78; effective thirtieth day thereafter (Register 78, No. 45).

3. Amendment of subsections (c) and (d) and new subsection (e) filed 7-11-89; operative 10-1-89 (Register 89, No. 28).

4. Amendment of section and Note filed 8-31-93; operative 8-31-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 36).

5. New subsection (e) and subsection relettering filed 3-27-95; operative 3-27-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 13).

6. Repealer and new section filed 11-9-98; operative 1-1-99 (Register 98, No. 46).

7. Amendment of subsections (e)(1), (f)(8) and (g) filed 12-22-2000; operative 1-1-2001 pursuant to Government Code section 11343.4(d) (Register 2000, No. 51).

8. Amendment of section and Note filed 5-20-2003; operative 6-19-2003 (Register 2003, No. 21).

9. Amendment of subsections (a)(1), (a)(8), (b)(3)-(4) and (g) and amendment of Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

10. Certificate of Compliance as to 12-31-2004 order, including further amendment of subsections (a)(1) and (g), transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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§9785.2. Form PR-2 “Primary Treating Physician's Progress Report.”

9785.2 Form PR-2 "Primary Treating Physician's Progress Report" [Form PR-2 attached]

NOTE

Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 4061.5, 4600, 4603.2, 4610, 4636, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 11-9-98; operative 1-1-99 (Register 98, No. 46).

2. Repealer and new form filed 12-22-2000; operative 1-1-2001 pursuant to Government Code section 11343.4(d) (Register 2000, No. 51).

3. Amendment of form filed 5-20-2003; operative 6-19-2003 (Register 2003, No. 21).

4. Amendment of section and Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day

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§9785.3. Form PR-3 “Primary Treating Physician's Permanent and Stationary Report.”

9785.3 Form PR-3 "Primary Treating Physician's Permanent and Stationary Report" [Form PR-3 attached]

NOTE

Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 4061.5, 4600, 4603.2, 4636, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 11-9-98; operative 1-1-99 (Register 98, No. 46).

2. Change without regulatory effect amending DWC Form PR-3, page 3, last sentence in the “Precipitating activity” narrative under the “Subjective Findings” section filed 12-30-98 pursuant to section 100, title 1, California Code of Regulations (Register 99, No. 1).

3. Repealer and new form filed 12-22-2000; operative 1-1-2001 pursuant to Government Code section 11343.4(d) (Register 2000, No. 51).

4. Amendment of form filed 5-20-2003; operative 6-19-2003 (Register 2003, No. 21).

5. Amendment of section and Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

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§9785.4. Form PR-4 “Primary Treating Physician's Permanent and Stationary Report.”

9785.4 Form PR-4 "Primary Treating Physician's Permanent and Stationary Report" [Form PR-4 attached]

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4600, 4061.5, 4603.2, 4636, 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

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§9785.5. Primary Treating Physician. (Repealed)

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

2. Amendment of subsection (d) filed 3-27-95; operative 3-27-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 13).

3. Repealer filed 11-9-98; operative 1-1-99 (Register 98, No. 46).

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§9786. Petition for Change of Primary Treating Physician.

(a) A claims administrator desiring a change of primary treating physician pursuant to Labor Code Section 4603 shall file with the Administrative Director a petition, verified under penalty of perjury, on the "Petition for Change of Primary Treating Physician" form (DWC-Form 280 (Part A)) contained in Section 9786.1.

The petition shall be accompanied by supportive documentary evidence relevant to the specific allegations raised. A proof of service by mail declaration shall be attached to the petition indicating that (1) the completed petition (Part A), (2) the supportive documentary evidence and (3) a blank copy of the "Response to Petition for Change of Primary Treating Physician", (DWC-Form 280 (Part B)), were served on the employee or, the employee's attorney, and the employee's current primary treating physician.

(b) Good cause to grant the petition shall be clearly shown by verified statement of facts, and, where appropriate, supportive documentary evidence. Good cause includes, but is not limited to any of the following:

(1) The primary treating physician has failed to comply with Section 9785, subdivisions (e), (f)(1-7), or (g) by not timely submitting a required report or submitting a report which is inadequate due to material omissions or deficiencies;

(2) The primary treating physician has failed to comply with subdivision (f)(8) of Section 9785 by failing to submit timely or complete progress reports on two or more occasions within the 12-month period immediately preceding the filing of the petition;

(3) A clear showing that the current treatment is not consistent with the treatment plan submitted pursuant to Section 9785, subdivisions (e) or (f);

(4) A clear showing that the primary treating physician or facility is not within a reasonable geographic area as determined by Section 9780(e).

(5) A clear showing that the primary treating physician has a possible conflict of interest, including but not limited to a familial, financial or employment relationship with the employee, which has a significant potential for interfering with the physician's ability to engage in objective and impartial medical decision making.

(c)(1) Where good cause is based on inadequate reporting under subdivisions (b)(1) or (b)(2), the petition must show, by documentation and verified statement, that the claims administrator notified the primary treating physician or facility in writing of the complete requirements of Section 9785 prior to the physician's failure to properly report.

(2) Good cause shall not include a showing that current treatment is inappropriate or that there is no present need for

medical treatment to cure or relieve from the effects of the injury or illness. The claims administrator's contention that current treatment is inappropriate, or that the employee is no longer in need of medical treatment to cure or relieve from the effects of the injury or illness should be directed to the Workers' Compensation Appeals Board, not the Administrative Director, in support of a Petition for Change of Primary Treating Physician.

(3) Where an allegation of good cause is based upon failure to timely issue the “Doctor's First Report of Occupational Injury or Illness,” Form DLSR 5021, within 5 working days of the initial examination pursuant to Section 9785(e)(1) or (e)(2), the petition setting forth such allegation shall be filed within 90 days of the initial examination.

(4) The failure to verify a letter response to a request for information made pursuant to Section 9785(f)(7), failure to verify a narrative report submitted pursuant to Section 9785(f)(8), or failure of the narrative report to conform to the format requirements of Section 9785(f)(8) shall not constitute good cause to grant the petition unless the claims administrator submits documentation showing that the physician was notified of the deficiency in the verification or reporting format and allowed a reasonable time to correct the deficiency.

(d) The employee, his or her attorney, and/or the primary treating physician may file with the Administrative Director a response to said petition, provided the response is verified under penalty of perjury and is filed and served on the claims administrator and all other parties no later than 20 days after service of the petition. The response may be accompanied by supportive documentary evidence relevant to the specific allegations raised in the petition. The response may be filed using the “Response to Petition for Change of Primary Treating Physician” form (DWC-Form 280 (Part B)) contained in Section 9786.1. Where the petition was served by mail, the time for filing a response shall be extended pursuant to the provisions of Code of Civil Procedure Section 1013. Unless good cause is shown, no other document will be considered by the Administrative Director except for the petition, the response, and supportive documentary evidence.

(e) The Administrative Director shall, within 45 days of the receipt of the petition, either:

(1) Dismiss the petition, without prejudice, for failure to meet the procedural requirements of this Section;

(2) Deny the petition pursuant to a finding that there is no good cause to require the employee to select a primary treating physician from the panel of physicians provided in the petition;

(3) Grant the petition and issue an order requiring the employee to select a physician from the panel of physicians provided in the petition, pursuant to a finding that good cause exists therefor;

(4) Refer the matter to the Workers' Compensation Appeals Board for hearing and determination by a Workers' Compensation Administrative Law Judge of such factual determinations as may be requested by the Administrative Director; or

(5) Issue a Notice of Intention to Grant the petition and an order requiring the submission of additional documents or information.

(f) The claims administrator's liability to pay for medical treatment by the primary treating physician shall continue until an order of the Administrative Director issues granting the petition.

(g) The Administrative Director may extend the time specified in Subsection (e) within which to act upon the claims administrator's petition for a period of 30 days and may order a party to submit additional documents or information.

NOTE

Authority cited: Sections 133, 139.5, 4603, 4603.2, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600, 4603 and 4603.2, Labor Code.

HISTORY

1. Repealer and new section filed 11-9-77; effective thirtieth day thereafter (Register 77, No. 46).

2. Amendment of subsections (a), (c), (d)(4), (e), and (f) filed 11-11-78; effective thirtieth day thereafter (Register 78, No. 45).

3. Amendment of subsection (a) filed 8-9-84; effective thirtieth day thereafter (Register 84, No. 35).

4. Change without regulatory effect of subsection (c) filed 7-11-86; effective upon filing (Register 86, No. 28).

5. Amendment of section and Note filed 8-31-93; operative 8-31-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 36).

6. Amendment of subsections (b)(5), (d), and (g) filed 3-27-95; operative 3-27-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 13).

7. Editorial correction of subsection (h) (Register 95, No. 29).

8. Editorial correction of inadvertently omitted subsection (d)(2) (Register 96, No. 52).

9. Amendment of subsection (f) and repealer and new subsection (g) filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

10. Amendment of section heading and section filed 12-22-2000; operative 1-1-2001 pursuant to Government Code section 11343.4(d) (Register 2000, No. 51).

11. Amendment filed 5-20-2003; operative 6-19-2003 (Register 2003, No. 21).

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§9786.1. Petition for Change of Primary Treating Physician; Response to Petition for Change of Primary Treating Physician (DWC Form 280 (Parts A and B).

NOTE: Authority cited: Sections 133, 139.5, 4603, 4603.2, 4603.5, and 5307.3, Labor Code. Reference: Sections 4600, 4603 and 4603.2, Labor Code.

HISTORY

1. New section (DWC form 280) filed 12-22-2000; operative 1-1-2001 pursuant to Government Code section 11343.4(d) (Register 2000, No. 51).

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New query

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§9787. Appeal from Administrative Director's Order Granting or Denying Petition for Change of Primary Treating Physician.

Any order denying or granting the claims administrator's petition whether issued with or without hearing, shall be final and binding upon the parties unless within 20 days from service thereof the aggrieved party petitions the Workers' Compensation Appeals Board for relief in the manner prescribed by Section 10950 of the Board's Rules of Practice and Procedure.

NOTE

Authority cited: Sections 133, 139.5, 4603.2, 4603.5 and 5307.3, Labor Code. Reference: Sections 4600, 4603 and 4603.2, Labor Code.

HISTORY

1. Repealer and new section filed 11-9-77; effective thirtieth day thereafter (Register 77, No. 46).

2. Amendment of section heading and section filed 12-22-2000; operative 1-1-2001 pursuant to Government Code section 11343.4(d) (Register 2000, No. 51).

3. Amendment of section and new Note filed 5-20-2003; operative 6-19-2003 (Register 2003, No. 21).

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§9788.01. Definitions

As used in this Article:

(a) “Agreed second opinion physician” is a physician agreed upon by an employer and represented employee pursuant to Labor Code Section 4062 subdivision (b).

(b) “Completion of the second opinion process” occurs on the forty-fifth day after the receipt of the treating physician's report by the employer, unless the time has been extended by mutual written consent of the parties as provided in these regulations, or unless the time has been extended as provided in these regulations because the employee failed to attend an examination with the second opinion physician or agreed second opinion physician.

(c) “CPTã” means the procedure codes set forth in the American Medical Association's Physicians' Current Procedural Terminology (CPT) 1997, copyright 1996, American Medical Association.

(d) “Income” of a person includes the income of that person's business partner, physician member of the office of a group practice as defined in Labor Code section 139.3, spouse, cohabitant, and immediate family. Income of a second opinion physician does not include income from employment which had terminated prior to the time the physician was selected as a second opinion physician where there is no reasonable prospect of future employment.

(e) “Material familial affiliation” means a relationship in which one of the persons or entities listed in subdivision (c) of Labor Code section 4062 is the parent, child, grandparent, grandchild, sibling, uncle, aunt, nephew, niece, spouse, or cohabitant of the second opinion physician. For entities of the employer, insurer, physician, medical group, independent practice association, administrator, utilization review entity, facility, or institution mentioned in subdivision (c) of Labor Code section 4062, which are not persons, the familial affiliation shall be determined by considering the relationship of all of the officers, directors, owners and management employees, and individual claims administrators and supervisors to the second opinion physician.

(f) “Material financial affiliation” includes all of the following financial relationships between the second opinion physician and another person or entity listed in subdivision (c) of Labor Code section 4062, or parent or subsidiary or otherwise related business entity of a person or entity:

(1) One has a direct or indirect investment worth two thousand dollars or more in the other;

(2) One is a director, officer, partner, trustee, employee, or holds any position of management in the other;

(3) One has a direct or indirect interest worth two thousand dollars or more in fair market value in an interest in real estate owned or controlled by the other;

(4) One has received income of any kind, including gifts, from the other, aggregating three hundred dollars or more within the twelve months prior to the time of selection as a second opinion physician, except that the following income shall not be counted for this purpose:

A. income for services as a second opinion physician;

B. income for services as a treating physician;

C. income for services as an agreed medical examiner;

D. income for services as a panel Qualified Medical Evaluator selected for unrepresented employees;

E. income from services as a Qualified Medical Evaluator for represented employees.

F. income for services as a Qualified Medical Evaluator for an employer from the first five cases in any twelve month period for the same employer, carrier, or administrator.

(5) One has an employment or promise of employment relationship with the other.

(g) “Material professional affiliation” is any relationship in which the second opinion physician shares office space with, or works in the same office of, any of the other persons or entities listed in subdivision (c) of Labor Code section 4062.

(h) “Parent, subsidiary, and otherwise related business entity” have the same meanings as in Section 18703.1, Title 2, Division 6 of the California Code of Regulations.

(i) “Receipt of the treating physician's report” is the day it was first received by the employer, insurance carrier, or administrator.

(j) “Retired spinal surgeon” is a physician currently licensed in the State of California who once had, but no longer has, hospital privileges to perform spinal surgery described in Section 9788.2(c)(2). “Retired spinal surgeon” does not include a physician whose hospital privileges to perform spinal surgery were either surrendered by the physician or were terminated or not renewed by the hospital, after disciplinary charges were filed or after a disciplinary investigation was commenced.

(k) “Second opinion physician” is the physician who is randomly selected pursuant to subdivision (b) of Labor Code section 4062 to render the second opinion on a treating physician's recommendation of spinal surgery.

(l) “Spinal surgery” includes:

(1) any of the procedures listed in the Official Medical Fee Schedule denominated by the following CPTR procedure code numbers: 22100, 22101, 22102, 22103, 22110, 22112, 22114, 22116, 22210, 22212, 22214, 22216, 22220, 22222, 22224, 22226, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22850, 22851, 22852, 22855; 22899; 62287, 62292, 63001 through 63615; and,

(2) any other procedure, which is not listed in subdivision (l)(1), which is a non-diagnostic invasive procedure to the spine or associated anatomical structures to perform an operative or curative procedure which is not primarily an analgesic procedure; and,

(3) any procedure which involves the introduction of energy, a foreign substance, or a device that destroys tissue in the spine and/or associated structures, including nerves and disks, or involves the implantation of devices into the spine and associated structures, including nerves and disks, and which is not primarily an analgesic procedure;

(4) Notwithstanding subdivisions (1) through (3), “spinal surgery” does not include penetration of the body by needles

in the performance of acupuncture by a practitioner whose license permits the performance of acupuncture, nor does “spinal surgery” include surgery which is required because of a bona fide medical emergency.

NOTE

Authority cited: Sections 133, 5307.1 and 5307.3, Labor Code. Reference: Sections 4062(b) and 4600, Labor Code.

HISTORY

1. New article 5.1 (sections 9788.01-9788.91) and section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 7-2-2004 order, including amendment of subsection (l)(1), transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

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New query

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§9788.1. Employer's Objection To Report Of Treating Physician Recommending Spinal Surgery.

(a) An objection to the treating physician's recommendation for spinal surgery shall be written on the form prescribed by the Administrative Director in Section 9788.11. The employer shall include with the objection a copy of the treating physician's report containing the recommendation to which the employer objects. The objection shall include the employer's reasons, specific to the employee, for the objection to the recommended procedure. The form must be executed by a principal or employee of the employer, insurance carrier, or administrator.

(b) Declarations.

(1) Declaration as to receipt of treating physician's recommendation.

The employer's objection shall include one of two versions of a declaration made under penalty of perjury regarding the date the report containing the treating physician's recommendation was first received by the employer, employer's insurance carrier, or administrator, in the format of the form prescribed by Section 9788.11.

Version A of the declaration shall be used if the declarant has personal knowledge of all the facts. Version B of the declaration may be used if the recipient employer, insurance carrier or administrator has a written policy of date-stamping every piece of mail on the date it was delivered to its office, this policy is consistently followed, the declarant is knowledgeable about the policy, and the report bears a legible date stamp showing when it was received in the office.

The declaration must be executed by a principal or employee of the employer, insurance carrier, or administrator.

(2) Declaration as to service of objection.

The employer's objection shall include a declaration made under penalty of perjury, in the format of the form prescribed by Section 9788.11 as to the date and time the objection was served, and the manner in which the objection was served.

The declaration must be executed by a principal or employee of the employer, insurance carrier, or administrator.

(c) Service of Objection.

(1) The employer shall serve the objection and the report containing the treating physician's recommendation on the Administrative Director, the employee, the employee's attorney, if any, and on the treating physician within 10 days of receipt of the treating physician's report containing the recommendation. An objection which is mailed to the Administrative Director and is received more than ten days after the date of receipt of the treating physician's report is

untimely unless it bears a postmark date no later than the tenth day after the date of receipt of the treating physician's report. The employer shall serve the original of the objection on the Administrative Director.

(2) Service on the Administrative Director shall be by mail or physical delivery. Service on the employee, employee's attorney, and treating physician shall be by mail or physical delivery or, if prior consent has been obtained from the recipient to be served by fax, may be by fax.

(d) If after an employer has served the objection on the Administrative Director, either the employer and a represented employee agree to an agreed second opinion physician or the employer withdraws its objection to the treating physician's recommendation for spinal surgery, the employer shall notify the Administrative Director within one working day of the agreement or withdrawal of objection. This notification may be by fax.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4062(b) and 4600, Labor Code.

HISTORY

1. New section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 7-2-2004 order, including amendment of section, transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

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New query

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§9788.11. Form for Employer's Objection To Report Of Treating Physician Recommending Spinal Surgery.

DWC form 233 (.pdf document)

This form, together with the report of the treating physician containing the recommendation for treatment which is objected to, is to be mailed to the Administrative Director, Medical Unit, P.O. Box 8888, San Francisco, CA 94128-8888, and copies served by mail or physical delivery or fax on the employee, employee's attorney, and treating physician. The objection form and report may be served on the employee, employee's attorney, and treating physician by fax, but only if prior consent has been obtained from the recipient to be served by fax. This form may not be served on the Administrative Director by fax. This Objection must be sent within ten (10) days of the first receipt by any of the employer, insurance carrier, or administrator, of the treating physician's report containing the recommendation.

Declarations

The form contains two declarations to be signed under penalty of perjury. The first is a declaration specifying the date that the report containing the treating physician's recommendation was first received by the employer, insurance carrier, or administrator. The second declaration specifies the date and manner of serving of the objection.

The form includes two versions of the declaration specifying the date of receipt of the report. Only one version needs to be completed. Version A shall be completed by an employee having personal knowledge of the facts of when the report was received, such as the person who opened the mail. Version B shall be completed by an employee who knows from the date stamp when the report was received, if all mail to the firm is date-stamped on the date it is received, the signer is readily knowledgeable about the policy, the policy is consistently followed, and the report bears a legible date stamp.

The declaration regarding service of the objection must be signed by the person having knowledge of how the report was served.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4062(b) and 4600, Labor Code.

HISTORY

1. New section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 7-2-2004 order, including repealer and new form, transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

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New query

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§9788.2. Qualifications of Spinal Surgery Second Opinion Physicians.

(a) An agreed second opinion physician may be any California licensed board-certified or board-eligible orthopaedic surgeon or neurosurgeon.

(b) The Administrative Director shall maintain a list of qualified surgeons who have applied, and whom the Administrative Director has found to be eligible to give second opinions under Labor Code § 4062 (b) after random selection by the Administrative Director.

(c) To apply to be on the Administrative Director's list, a physician shall demonstrate to the satisfaction of the Administrative Director that the physician:

(1) Is currently board certified either as a neurosurgeon by the American Board of Neurological Surgery or the American Osteopathic Board of Surgery, or as an orthopaedic surgeon by either the American Board of Orthopaedic Surgery or the American Osteopathic Board of Orthopedic Surgery;

(2) Has current hospital privileges in good standing at an accredited hospital in California to perform spinal surgery without proctoring;

(3) Has an unrestricted license as a physician and surgeon in California;

(4) Has no record of previous discipline by any governmental physician licensing agency, and is not then under accusation by any governmental physician licensing agency;

(5) Has not been terminated or had discipline imposed by the Industrial Medical Council or Administrative Director in relation to the physician's role as a Qualified Medical Evaluator; is not then under accusation by the Industrial Medical Council or Administrative Director; has not been denied renewal of Qualified Medical Evaluator status, except for non-completion of continuing education or for non-payment of fees; has neither resigned nor failed to renew Qualified Medical Evaluator status while under accusation or probation by the Industrial Medical Council or Administrative Director or after notification that reappointment as a Qualified Medical Evaluator may or would be denied for reasons other than non-completion of continuing education or non-payment of fees; and has not filed any applications or forms with the Industrial Medical Council or Administrative Director which contained any untrue material statements; and

(6) Has not been convicted of any crime involving dishonesty or any crime of moral turpitude.

(d) The Administrative Director may also accept to be on the list a retired spinal surgeon who does not meet the qualifications of subdivision (c)(2), but who does meet the qualifications of subdivisions (c)(1), (c)(3), (c)(5), (c)(6), and either (c)(4) or (e), if the retired spinal surgeon met the qualifications of subdivision (c)(2) within three years of

application. The qualification of such physician shall not extend longer than three years from the last time the physician met the requirements of subdivision (c)(2).

(e) The Administrative Director may also accept to be on the list a physician who does not meet the qualifications of subdivision (c)(4), but who does meet the qualifications of subdivisions (c)(1), (c)(2), (c)(5), (c)(6), and either (c)(3) or (d), if at least five years have elapsed since discipline was imposed, the physician is not currently the subject of a discipline accusation, and the Administrative Director finds that the physician has been rehabilitated.

NOTE

Authority: Sections 133 and 5307.3, Labor Code. Reference: Sections 4062(b) and 4600, Labor Code.

HISTORY

1. New section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 7-2-2004 order transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

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§9788.3. Application Procedures.

Physicians seeking to serve as a second opinion physician shall:

(a) Make application to the Administrative Director on the form prescribed by the Administrative Director in Section 9788.31.

(b) Furnish certified copies of their board certification and hospital privileges, and shall submit other documentation of their qualifications as the Administrative Director may require.

(c) Both after making application, and after being notified by the Administrative Director that the application has been accepted, the physician shall keep the Administrative Director informed of any change of address, telephone, or fax number.

(d) The physician shall also notify the Administrative Director within 10 days, if the California Medical Board, or any other state medical board from whom the physician is licensed, files any accusation or charges against the physician, or imposes any discipline.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4062(b) and 4600, Labor Code.

HISTORY

1. New section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 7-2-2004 order, including new subsection (d), transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

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§9788.31. Application Form.

DWC form 232 (.pdf document)

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4062(b) and 4600, Labor Code

HISTORY

1. New section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 7-2-2004 order transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

3. Change without regulatory effect amending form filed 10-18-2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No.42).

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§9788.32.

Administrative Director's Action on Application.

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a) After reviewing a completed application, if the Administrative Director finds that the applicant meets the qualifications, he/she shall notify the applicant by mail, and add the applicant's name to the list of second opinion physicians.

(b) If a physician applicant does not qualify only because the physician has a record of previous discipline by a governmental physician licensing agency and if at least five years have elapsed since discipline was imposed, the Administrative Director shall notify the physician that the physician may within ninety days submit written evidence of the physician's rehabilitation from the offenses or inadequacies for which discipline was imposed. If no evidence is submitted within that time period, the Administrative Director shall reject the application. If the physician submits evidence, the Administrative Director shall consider any written evidence submitted by the physician along with any other evidence the Administrative Director may obtain through investigation. The Administrative Director shall make a finding as to whether the physician has been rehabilitated from the offenses or inadequacies for which discipline was imposed. If the Administrative Director does not find that the physician has been rehabilitated, the Administrative Director shall reject the application.

(c) If the Administrative Director finally determines that an applicant does not meet the qualifications, he/she shall notify the applicant by mail that the application is rejected.

(d) An applicant whose application has been rejected may, within 30 days of the mailing of the notice of rejection, request a hearing by filing a written request for hearing with the Administrative Director. If a written request for hearing is not received by the Administrative Director within 30 days of the mailing of the notice of rejection, the applicant shall be deemed to have waived any appeal or request for hearing.

(e) Upon receipt of a written request for hearing, the Administrative Director shall serve a statement of issues, as provided in Government Code section 11504.

(f) Hearings shall be held under the procedures of Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code (commencing with section 11500) and the regulations of the Office of Administrative Hearings (California Code of Regulations, Title 1, Division 2).

(g) Failure to file timely a mailed notice of defense or failure to appear at a noticed hearing or conference shall constitute a waiver of a right to a hearing.

(h) An applicant whose application has been rejected may reapply after:

1. one year has elapsed from the date his application was rejected; or

2. the time when the deficiencies which were the reasons for rejection have been corrected;

whichever occurs first.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code; and Sections 11400.20 and 11415.10, Government Code. Reference: Sections 4062(b) and 4600, Labor Code.

HISTORY

1. New section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 7-2-2004 order transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

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§9788.4. Removal of Physicians from the Spinal Surgery Second Opinion Physician List.

(a) The Administrative Director may remove from the list any physician whenever the Administrative Director learns:

(1) That the physician no longer meets the qualifications to be on the list; or

(2) That the California Medical Board, or any other state medical board from whom the physician is licensed, has filed any accusation against the physician; or

(3) That the physician, having been notified by the Administrative Director of the physician's selection to render a second opinion in any case, has not served the second opinion report in that case within forty-five days after the receipt of the treating physician's report by the employer, unless the employee failed to attend an examination; or

(4) That the physician's application to be on the list contained statements which were not true; or

(5) That the physician has at any time failed to disclose to the Administrative Director that the physician had a material professional, familial, or financial affiliation with any of the persons or entities listed in subdivision (c) of Labor Code section 4062 in any case in which the physician had been selected as a second opinion physician.

(6) That the physician has declined to accept assignment as a second opinion physician at any time except during a period for which the physician had notified the Administrative Director of unavailability per Section 9788.45.

(7) That the physician has filed notifications of unavailability for more than 120 days of any one year period. The first one year period shall commence with the date the physician was added to the list of spinal surgery second opinion physicians by the Administrative Director.

(b) Upon removal of a physician from the list, the Administrative Director shall advise the physician by mail of the removal, the Administrative Director's reasons for removal, and the right to request a hearing on the removal.

(c) A physician who has been mailed a notice of removal from the list may, within 30 days of the mailing of the notice of removal, request a hearing by filing a written request for hearing with the Administrative Director. If a written request for hearing is not received by the Administrative Director within 30 days of the mailing of the notice of removal, the physician shall be deemed to have waived any appeal or request for hearing.

(d) Upon receipt of a written request for hearing, the Administrative Director shall serve an accusation, as provided in Government Code section 11503.

(e) Hearings shall be held under the procedures of Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code (commencing with section 11500) and the regulations of the Office of Administrative Hearings (California Code of Regulations, Title 1, Division 2).

(f) Failure to file timely a mailed notice of defense or failure to appear at a noticed hearing or conference shall constitute a waiver of a right to a hearing.

(g) A physician who has been removed from the list may petition for reinstatement after one year has elapsed since the effective date of the decision on the physician's removal. The provisions of Government Code section 11522 shall apply to such petition.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code; and Sections 11400.20, 11415.10 and 11522, Government Code. Reference: Sections 4062(b) and 4600, Labor Code.

HISTORY

1. New section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 7-2-2004 order, including amendment of section, transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

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§9788.45. Unavailability of Second Opinion Physician.

A physician who will be unavailable to accept assignments for a period of 30 days or more for any reason, shall, at least 30 days prior to a period of unavailability, notify the Administrative Director in writing of the dates of the physician's unavailability.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4062(b) and 4600, Labor Code.

HISTORY

1. New section filed 12-15-2004; operative 12-15-2004 (Register 2004, No. 51).

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§9788.5. Random Selection of Second Opinion Physician.

(a) Within five (5) working days of the Administrative Director's receipt of an objection to a recommendation for spinal surgery, the Administrative Director shall randomly select a physician from those listed physicians located within a thirty (30) mile radius of the employee's address, provided that six physicians are located within that radius; and if six are not located within that radius, using ever increasing radii, until at least six (6) physicians are located from which a random selection may be made. The Administrative Director shall not include among the six physicians any physician that the Administrative Director has determined, from the information submitted to the Administrative Director by the physician and by the employer objecting to the treating physician's recommendation, has a material affiliation prohibited by subdivision (c) of Labor Code section 4062. The selected second opinion physician shall notify the Administrative Director if he/she has a material professional, familial, or financial affiliation with any of the persons or entities listed in subdivision (c) of Labor Code section 4062, within five working days of the physician's receipt of notification of selection. Upon such notification, the Administrative Director shall immediately select a replacement second opinion physician.

(b) Until the Administrative Director shall have a computerized system for random selection of physicians, the Administrative Director shall manually make random selections as in subdivision (a), except that instead of using an initial thirty mile radius, the Administrative Director shall select from those physicians located within the same zipcode as the employee's address, or if there are not at least six physicians located within that zipcode, then additional adjacent zipcodes shall be used until there are at least six physicians found within the geographic area of selection.

(c) Upon selection by the Administrative Director, the second opinion physician shall, unless the physician notifies the Administrative Director of a material professional, familial, or financial affiliation, notify the parties within five working days of the physician's receipt of notification of selection of the date and time of any appointment for examination of the employee. If the physician arranges an appointment with the employee by telephone, the physician shall thereafter send the employee a written notice containing the details of the appointment.

(d) Within ten days of the selection of a second opinion physician, either the employer or the employee may object to the selection on the basis that the second opinion physician has a material professional, familial, or financial affiliation with any of the persons or entities listed in subdivision (c) of Labor Code section 4062, by filing a written objection with the Administrative Director and serving the other parties. The Administrative Director may either sustain the objection, in which case a new selection shall be made, or deny the objection.

(e) The Administrative Director shall exclude from the selection process any physician who has notified the Administrative Director of unavailability pursuant to Section 9788.45.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4062(b) and 4600, Labor Code.

HISTORY

1. New section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 7-2-2004 order, including amendment of subsection (c) and new subsection (e), transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

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§9788.6. Examination by Second Opinion Physician or Agreed Second Opinion Physician.

(a) The second opinion physician or agreed second opinion physician may physically examine the patient-employee, if the second opinion physician or agreed second opinion physician determines in his or her sole discretion that an examination of the patient-employee is required, but nevertheless must physically examine the patient-employee before finally rendering a second opinion in all cases in which the second opinion physician or agreed second opinion physician disagrees with the recommendation of the treating physician. If there is to be a physical examination of the patient-employee, the second opinion physician or agreed second opinion physician shall schedule the examination, and shall, at least ten days in advance of the scheduled examination, send written notice of the date, time, and place of the examination to the employee, the employee's attorney, if any, and the party who objected to the recommended surgery.

(b) The employer shall, and the employee may, furnish all relevant medical records to the second opinion physician or agreed second opinion physician, including x-ray, MRI, CT, and other diagnostic films, and any medical reports which describe the employee's current spinal condition or contain a recommendation for treatment of the employee's spinal diagnoses. The employer shall serve all reports and records on the employee, except for x-ray, MRI, CT and other diagnostic films and for other records which have been previously served on the employee. If a special form of transportation is required because of the employee's medical condition, it is the obligation of the employer to arrange for it. The employer shall furnish transportation expense in advance of the examination. Except for during the examination, a second opinion physician or agreed second opinion physician shall have no ex parte contact with any party.

(1) In the case of a represented employee, except for matters dealing with the scheduling of appointments, missed appointments, the furnishing of records and reports, and the availability of the report, all communications between a second opinion physician or agreed second opinion physician and any party shall be in writing, with copies served on the other parties.

(2) In the case of an unrepresented employee, except for during the examination and for matters dealing with the scheduling of appointments, missed appointments, the furnishing of records and reports, and the availability of the report, there shall be no communications between any party and a second opinion physician until after the report has been served.

(c) If the employee fails to attend an examination with a second opinion physician or agreed second opinion physician, and the physician is unable to reschedule the employee's appointment before the 35th day after receipt of the treating physician's report, the time to complete the second opinion process shall be extended for an additional 30 days. If a second opinion physician is unable to schedule another examination within the 30 additional days, the Administrative Director, upon request, will select another second opinion physician.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4062(b) and 4600, Labor Code.

HISTORY

1. New section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 7-2-2004 order, including amendment of section, transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

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§9788.7. Contents Of Second Opinion and Agreed Second Opinion Physician Reports.

(a) If the second opinion physician or agreed second opinion physician disagrees with the recommendation of the treating physician, the second opinion physician's or agreed second opinion physician's report may include a recommendation for a different treatment or therapy.

(b) Reports of second opinion physicians and agreed second opinion physicians shall include, where applicable:

(1) The date of the examination;

(2) The patient's complaints;

(3) A listing of all information received from the parties reviewed in preparation of the report or relied upon for the formulation of the physician's opinion;

(4) The patient's medical history relevant to the treatment determination;

(5) Findings on record review or examination;

(6) The relevant diagnosis;

(7) The physician's opinion whether or not the proposed spinal surgery is appropriate or indicated, and any alternate treatment recommendations;

(8) The reasons for the opinion, including a reference to any treatment guidelines referred to or relied upon in assessing the proposed medical care;

(9) The signature of the physician.

(c) Second opinion physicians and agreed second opinion physicians shall serve with each report the following executed declaration made under penalty of perjury:

“In connection with the preparation and submission of the attached report of second opinion on recommended spinal surgery, I declare, on the date next written, under penalty of perjury of the laws of the State of California, that I have no material familial affiliation, material financial affiliation, or material professional affiliation prohibited by Labor Code Section 4062, subdivision (c).

_____ _____

date signature”

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4062(b) and 4600, Labor Code.

HISTORY

1. New section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 7-2-2004 order transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

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§9788.8. Time Limits For Providing Reports.

Second opinion physicians and agreed second opinion physicians shall simultaneously serve the report on the Administrative Director, the employer, the employee, and the employee's attorney, if any, as soon as possible, but in any event within forty-five days of receipt of the treating physician's report (as defined herein), unless the parties have agreed in writing to extend the time to a later date.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4062(b) and 4600, Labor Code

HISTORY

1. New section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 7-2-2004 order, including amendment of section, transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

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§9788.9. Charges for Services of Second Opinion Physician and Agreed Second Opinion Physician

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Payment for the services of the second opinion physician shall be made by the employer. The fee shall be:

(a) if the physician examines the injured worker, the same as the fee allowed under Section 9795 for a Basic Comprehensive Medical-Legal Evaluation, without modifiers which might otherwise be allowed under Section 9795(d); or,

(b) if the physician does not examine the injured worker, one half of the fee allowed under Section 9795 for a Basic Comprehensive Medical-Legal Evaluation, without modifiers which might otherwise be allowed under Section 9795(d).

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4062(b) and 4600, Labor Code.

HISTORY

1. New section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 7-2-2004 order transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

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§9788.91. Filing of a Declaration of Readiness to Proceed.

(a) If the report of the second opinion physician or agreed second opinion physician concurs with the treating physician's recommendation for surgery, the employer shall authorize the surgery and communicate that authorization to the treating physician within three working days of receipt of the second opinion physician's report.

(b) If the report of the second opinion physician or agreed second opinion physician does not concur with the treating physician's recommendation for surgery, the employer shall file a declaration of readiness to proceed within 14 days of receipt of the second opinion physician's report, unless the parties agree with the determination of the second opinion physician or agreed second opinion physician, or unless the employer has authorized the surgery.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4062(b) and 4600, Labor Code.

HISTORY

1. New section filed 7-2-2004 as an emergency; operative 7-2-2004 (Register 2004, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-1-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 7-2-2004 order, including amendment of section, transmitted to OAL 11-1-2004 and filed 12-15-2004 (Register 2004, No. 51).

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SUBCHAPTER 1. ADMINISTRATIVE DIRECTOR -ADMINISTRATIVE RULES
Article 5.3. Official Medical Fee Schedule -- Services Rendered after January 1, 2004

New query

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§9789.10. Physician Services - Definitions.

(a) “Basic value” means the unit value for an anesthesia procedure that is set forth in the Official Medical Fee Schedule 2003.

(b) “CMS” means the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.

(c) “Conversion factor” or “CF” means the factor set forth below for the applicable OMFS section:

Evaluation and Management	$8.50
Medicine	$6.15
Surgery	$153.00
Radiology	$12.50
Pathology	$1.50
Anesthesia	$34.50

(d) “CPTÒ” means the procedure codes set forth in the American Medical Association's Physicians' Current Procedural Terminology (CPT) 1997, copyright 1996, American Medical Association, or the Physicians' Current Procedural Terminology (CPT) 1994, copyright 1993, American Medical Association.

(e) “Medicare rate” means the physician fee schedule rate derived from the Resource Based Relative Value Scale and related data, adopted for the Calendar Year 2004, published in the Federal Register on January 7, 2004, Volume 69, No. 4, pages 1117 through 1242 (CMS-1372-IFC), as amended by CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 105 (February 20, 2004). The Medicare rate for each procedure is derived by the Administrative Director utilizing the non-facility rate (or facility rate if no non-facility rate exists), and a weighted average geographic adjustment factor of 1.063.

(f) “Modifying units” means the anesthesia modifiers and qualifying circumstances as set forth in the Official Medical Fee Schedule 2003.

(g) “Official Medical Fee Schedule” or “OMFS” means Article 5.3 of Subchapter 1 of Chapter 4.5 of Title 8, California Code of Regulations (Sections 9789.10 - 9789.111), adopted pursuant to Section 5307.1 of the Labor Code for all medical services, goods, and treatment provided pursuant to Labor Code Section 4600.

(h) “Official Medical Fee Schedule 2003” or “OMFS 2003” means the Official Medical Fee Schedule incorporated

into Section 9791.1 in effect on December 31, 2003, which consists of the OMFS book revised April 1, 1999 and as amended for dates of service on or after July 12, 2002.

(i) “Percentage reduction calculation” means the factor set forth in Table A for each procedure code which will result in a reduction of the OMFS 2003 rate by 5%, or a lesser percent so that the reduction results in a rate that is no lower than the Medicare rate.

(j) “Physician service” means professional medical service that can be provided by a physician, as defined in Section 3209.3 of the Labor Code, and is subject to reimbursement under the Official Medical Fee Schedule. For purposes of the OMFS, “physician service” includes service rendered by a physician or by a non-physician who is acting under the supervision, instruction, referral or prescription of a physician, including but not limited to a physician assistant, nurse practitioner, clinical nurse specialist, and physical therapist.

(k) “RVU” means the relative value unit for a particular procedure that is set forth in the Official Medical Fee Schedule 2003.

(l) “Time value” means the unit of time indicating the duration of an anesthesia procedure that is set forth in the Official Medical Fee Schedule 2003.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New article 5.3 (sections 9789.10-9789.110) and section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of article heading, new introductory paragraph and amendment of subsections (d), (e) and (g), transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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SUBCHAPTER 1. ADMINISTRATIVE DIRECTOR -ADMINISTRATIVE RULES
Article 5.3. Official Medical Fee Schedule -- Services Rendered after January 1, 2004

New query

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§9789.11. Physician Services Rendered After January 1, 2004.

(a) Except as specified below, or otherwise provided in this Article, the ground rule materials set forth in each individual section of the OMFS 2003 are applicable to physician services rendered on or after July 1, 2004.

(1) The OMFS 2003's "General Information and Instructions" section is not applicable. The "General Information and Instructions, Effective for Dates of Service on or after July 1, 2004," are incorporated by reference and will be made available on the Division of Workers' Compensation Internet site http:// www.dir.ca.gov/DWC/OMFS9904.htm or upon request to the Administrative Director at:

Division of Workers' Compensation (Attention: OMFS - Physician Services)
P.O. Box 420603
San Francisco, CA 94142

(b) For physician services rendered on or after July 1, 2004 the maximum allowable reimbursement amount set forth in the OMFS 2003 for each procedure code is reduced by five (5) percent, except that those procedures that are reimbursed under OMFS 2003 at a rate between 100% and 105% of the Medicare rate will be reduced between zero and 5% so that the OMFS reimbursement will not fall below the Medicare rate. The reduction rate for each procedure is set forth as the adjustment factor in Table A. Reimbursement for procedures that are reimbursed under OMFS 2003 at a rate below the Medicare rate will not be reduced.

(c)(1) Table A, "OMFS Physician Services Fees for Services Rendered on or after July 1, 2004," which sets forth each individual procedure code with its corresponding relative value, conversion factor, percentage reduction calculation (between 0 and 5.0%), and maximum reimbursable fee, is incorporated by reference.

(2) Table A, "OMFS Physician Services Fees for Services Rendered on or after January 14, 2005," which sets forth each individual procedure code with its corresponding relative value, conversion factor, percentage reduction calculation (between 0 and 5.0%), and maximum reimbursable fee, is incorporated by reference.

(3) Table A, "OMFS Physician Services Fees for Services Rendered on or after May 14, 2005," which sets forth each individual procedure code with its corresponding relative value, conversion factor, percentage reduction calculation (between 0 and 5.0%), and maximum reimbursable fee, is incorporated by reference.

(4) Table A and its addenda may be obtained from the Division of Workers' Compensation Internet site http://www.dir.ca.gov/DWC/OMFS9904.htm or upon request to the Administrative Director at:

Division of Workers' Compensation (Attention: OMFS - Physician Services)
P.O. Box 420603

San Francisco, CA 94142

(d)(1) Except for anesthesia services, to determine the maximum allowable reimbursement for a physician service rendered on or after July 1, 2004 the following formula is utilized: RVU x conversion factor y percentage reduction calculation = maximum reasonable fee before application of ground rules. Applicable ground rules set forth in the OMFS 2003 and the "General Information and Instructions, Effective for Dates of Service on or after July 1, 2004," are then applied to calculate the maximum reasonable fee.

(2) To determine the maximum allowable reimbursement for anesthesia services (CPT Codes 00100 through 01999) rendered after January 1, 2004, the following formula is utilized: (basic value + modifying units (if any) + time value) y (conversion factor x .95) = maximum reasonable fee.

(e) The following procedures in the Pathology and Laboratory section (both professional and technical component) will be reimbursed under this section: CPT Codes 80500, 80502; 85060 through 85102; 86077 through 86079; 87164; and 88000 through 88399. All other pathology and laboratory services will be reimbursed pursuant to Section 9789.50, including but not limited to: CPT Codes 80002 through 80440; 81000 through 85048; 85130 through 86063; 86140 through 87163; 87166 through 87999; and 89050 through 89399.

(f) For physician services rendered on or after February 15, 2007, the maximum allowable reimbursement amounts for procedure codes 99201 through 99205 and 99211 through 99215 are set forth in the February, 2007 Addendum to Table A, "OMFS Physician Services Fees for Services Rendered on or after February 15, 2007." The February, 2007 Addendum to Table A, "OMFS Physician Services Fees for Services Rendered on or after February 15, 2007", which sets forth individual procedure codes with the corresponding maximum reimbursable fees, is incorporated by reference.

<General Materials (GM) - References, Annotations, or Tables>

Note: Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of section heading and section, transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

3. Amendment of subsection (a)(1), redesignation and amendment of former subsection (c) as new subsections (c)(1) and (c)(3), new subsection (c)(2) and adoption of new revision of Table A (incorporated by reference) filed 12-15-2004 as an emergency; operative 1-14-2005 (Register 2004, No. 51). A Certificate of Compliance must be transmitted to OAL by 5-16-2005 or emergency language will be repealed by operation of law on the following day.

4. Readoption of 12-15-2004 order, with additional amendments, filed 5-12-2005 as an emergency; operative 5-14-2005 (Register 2005, No. 19). A Certificate
of Compliance must be transmitted to OAL by 9-12-2005 or emergency language will be repealed by operation of law on the following day.

5. Certificate of Compliance as to 5-12-2005 order transmitted to OAL 8-22-2005 and filed 9-29-2005 (Register 2005, No. 39).

6. Amendment of subsection (c)(4) and new subsection (f) submitted to the Office of Administrative Law for printing only as exempt from the Administrative Procedure Act and review by the Office of Administrative Law pursuant to section 11340(g) of the Government Code (Register 2007, No.7).

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New query

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§9789.20. General Information for Inpatient Hospital Fee Schedule -- Discharge after January 1, 2004

(a) This Inpatient Hospital Fee Schedule section of the Official Medical Fee Schedule covers charges made by a hospital for inpatient services provided by the hospital.

(b) Charges by a hospital for the professional component of medical services for physician services shall be paid according to Sections 9789.10 through 9789.11.

(c) Sections 9789.20 through 9789.24 shall apply to all bills for inpatient services with a date of discharge on or after July 1, 2004. Services for discharges after January 1, 2004, but before July 1, 2004 are governed by the “emergency” regulations that were effective on January 2, 2004. Bills for services with date of admission on or before December 31, 2003 will be reimbursed in accordance with Section 9792.1.

(d) The Inpatient Hospital Fee schedule shall be adjusted to conform to any relevant changes in the Medicare payment schedule, including mid-year changes no later than 60 days after the effective date of those changes. Updates shall be posted on the Division of Workers' Compensation webpage at http://www.dir.ca.gov/DWC/dwc_home_page.htm. The annual updates to the Inpatient Hospital Fee schedule shall be effective every year on October 1.

(e) Any document incorporated by reference in Sections 9789.20 through 9789.24 is available from the Division of Workers' Compensation Internet site (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:

DIVISION OF WORKERS' COMPENSATION
(ATTENTION: OMFS)
P.O. BOX 420603
SAN FRANCISCO, CA 94142

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2, 5307.1, and 5318 Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of section heading and subsections (c) and (d), transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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§9789.21. Definitions for Inpatient Hospital Fee Schedule.

(a) “Average length of stay” means the geometric mean length of stay for a diagnosis-related group assigned by CMS.

(b) “Capital outlier factor” means fixed loss cost outlier threshold x capital wage index x large urban add-on x (capital cost-to-charge ratio/total cost-to-charge ratio).

(1) The capital wage index, also referred to as the capital geographic factor (GAF), is specified in the Federal Register of October 6, 2003 (correcting the rule published on August 1, 2003) at Vol. 68, page 57736, Table 4A for urban areas, Table 4B on page 57743 for rural areas, and Table 4C on page 57744 for reclassified hospitals, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(2) The “large urban add-on” is indicated by the post-reclassification urban/rural location published in the Payment Impact File at positions 229-235. As stated in Title 42, Code of Federal Regulations, Section 412.316(b), as it is in effect on November 11, 2003, the “large urban add-on” is an additional 3% of what would otherwise be payable to the health facility.

(3) “Fixed loss cost outlier threshold” means the Medicare fixed loss cost outlier threshold for inpatient admissions. The fixed loss cost outlier threshold for FY 2004 is $31,000 as published in the Federal Register of August 1, 2003 at volume 68, number 148 at page 45477.

(c) “CMS” means the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.

(d) “Composite factor” means the factor calculated by the administrative director for a health facility by adding the prospective operating costs and the prospective capital costs for the health facility, excluding the DRG weight and any applicable outlier and new technology payment, as determined by the federal Centers for Medicare & Medicaid Services (CMS) for the purpose of determining payment under Medicare.

(1) Prospective capital costs are determined by the following formula:

(A) Capital standard federal payment rate x capital geographic adjustment factor x large urban add-on x [1 + capital disproportionate share adjustment factor + capital indirect medical education adjustment factor]

(B) The “capital standard federal payment rate” is $414.18 as published by CMS in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68, page 57735, Table 1D, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(C) The “capital geographic adjustment factor” is published in the Payment Impact File at positions 243-252.

(D) The “large urban add-on” is indicated by the post-reclassification urban/rural location published in the Payment Impact File at positions 229-235. As stated in Title 42, Code of Federal Regulations, Section 412.316(b), effective November 11, 2003, the “large urban add-on” is an additional 3% of what would otherwise be payable to the health facility.

(E) The “capital disproportionate share adjustment factor” is published in the Payment Impact File at positions 117-126.

(F) The “capital indirect medical education adjustment factor” (capital IME adjustment) is published in Payment Impact File at positions 202-211.

(2) Prospective operating costs are determined by the following formula:

(A) [(Labor-related national standardized amount x operating wage index) + nonlabor-related national standardized amount] x [1 + operating disproportionate share adjustment factor + operating indirect medical education adjustment]

(B) The “labor-related national standardized amount” is $3,136.39, as published by the federal Centers for Medicare & Medicaid Services in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68 page 57735, Table 1A, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §401, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(C) The “operating wage index” is published in the Payment Impact File at positions 253-262.

(D) The “nonlabor-related national standardized amount” is $1,274.85, as published by CMS in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68, page 57735, Table 1A, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §401, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(E) The “operating disproportionate share adjustment factor” is published in the Payment Impact File at positions 127-136 and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §402, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(F) The “operating indirect medical education adjustment” is published in the Payment Impact File at positions 212-221 and as modified by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §502, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(G) For sole community hospitals, the operating component of the composite rate shall be the higher of the prospective operating costs determined using the formula in (2) or the hospital-specific rate published in the Payment Impact File at positions 137-145.

(3) A table of composite factors for each health facility in California is contained in Section 9789.23. The sole community hospital composite factors that incorporate the operating component specified in subdivision (d)(2)(G) are listed in italics in the column headed “Composite” set forth in Section 9789.23.

(e) “Costs” means the total billed charges for an admission, excluding non-medical charges such as television and telephone charges, charges for Durable Medical Equipment for in home use, charges for implantable medical devices, hardware, and/or instrumentation reimbursed under subdivision (f) of Section 9789.22, multiplied by the hospital's total

cost-to-charge ratio.

(f) “Cost-to-charge ratio” means the sum of the hospital specific operating cost-to-charge ratio and the hospital specific capital cost-to-charge ratio. The operating cost-to-charge ratio for each hospital is published in the Payment Impact File at positions 161-168. The capital cost-to-charge ratio for each hospital is published in the Payment Impact File at positions 99-106.

(g) “Cost outlier case” means a hospitalization for which the hospital's costs, as defined in subdivision (e) above, exceeds the cost outlier threshold.

(h) “Cost outlier threshold” means the sum of the Inpatient Hospital Fee Schedule payment amount, the payment for new medical services and technologies reimbursed under subdivision (g) of Section 9789.22, and the hospital specific outlier factor.

(i) “Diagnosis Related Group (DRG)” means the inpatient classification scheme used by CMS for hospital inpatient reimbursement. The DRG system classifies patients based on principal diagnosis, surgical procedure, age, presence of comorbidities and complications and other pertinent data.

(j) “DRG weight” means the weighting factor for a diagnosis-related group assigned by CMS for the purpose of determining payment under Medicare. Section 9789.24 lists the DRG weights and geometric mean lengths of stay as assigned by CMS.

(k) “FY” means the CMS fiscal year October 1 through September 30.

(l) “Health facility” means any facility as defined in Section 1250 of the Health and Safety Code.

(m) “Inpatient” means a person who has been admitted to a health facility for the purpose of receiving inpatient services. A person is considered an inpatient when he or she is formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or is transferred to another facility and does not actually remain overnight.

(n) “Inpatient Hospital Fee Schedule maximum payment amount” is that amount determined by multiplying the DRG weight x hospital composite factor x 1.20.

(o) “Labor-related portion” is that portion of operating costs attributable to labor costs, as specified in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68, page 57735, Table 1A, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(p) “Medical services” means those goods and services provided pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

(q) “Operating outlier factor” means ((fixed loss cost outlier threshold x ((labor-related portion x wage index) + nonlabor-related portion)) x (operating cost-to-charge ratio/ total cost-to-charge ratio)).

(1) The wage index, also referred to as operating wage index in the Payment Impact File at positions 253-262, is specified as the wage index at Federal Register of October 6, 2003 (correcting rule published on August 1, 2003) at Vol. 68, page 57736, Table 4A for urban areas; Table 4B on page 57743 for rural areas, and Table 4C on page 57744 for reclassified hospitals, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(2) The nonlabor-related portion is that portion of operating costs attributable to nonlabor costs as defined in the Federal Register of October 6, 2003 (correcting the publication of August 1, 2003), at Vol. 68, page 57735, Table 1A, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(r) “Outlier factor” means the sum of the capital outlier factor and the operating outlier factor. A table of hospital specific outlier factors for each health facility in California is contained in Section 9789.23.

(s) “Payment Impact File” means the FY 2004 Prospective Payment System Payment Impact File (October 2003 Update) (IMPFILE04) published by the federal Centers for Medicare & Medicaid Services (CMS), which document is hereby incorporated by reference. The description of the file is found at http://cms.hhs.gov/providers/hipps/impact_rcd_lay.pdf . The file is accessible through http://cms.hhs.gov/providers/hipps/ippspufs.asp. A paper copy of the Payment Impact File, with explanatory material, is available from the Administrative Director upon request. An electronic copy is available from the Administrative Director at http://www.dir.ca.gov/DWC/dwc_home_page.htm .

(t) “Professional Component” means the charges associated with a professional service provided to a patient by a hospital based physician. This component is billed separately from the inpatient charges.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2, 5307.1 and 5318, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of section, transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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New query

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§9789.22. Payment of Inpatient Hospital Services.

(a) Maximum payment for inpatient medical services shall be determined by multiplying 1.20 by the product of the health facility's composite factor and the applicable DRG weight. The fee determined under this subdivision shall be a global fee, constituting the maximum reimbursement to a health facility for inpatient medical services not exempted under this section. However, preadmission services rendered by a health facility more than 24 hours before admission are separately reimbursable.

(b) The maximum payment for inpatient medical services includes reimbursement for all of the inpatient operating costs specified in Title 42, Code of Federal Regulations, Section 412.2(c), effective date October 1, 2002 and revised as of October 1, 2003, which is incorporated by reference and will be made available upon request to the Administrative Director, and the inpatient capital-related costs specified in Title 42, Code of Federal Regulations, Section 412.2(d), effective date October 1, 2002 and revised as of October 1, 2003, which is incorporated by reference and will be made available upon request to the Administrative Director.

(c) The maximum payment shall include the cost items specified in Title 42, Code of Federal Regulations, Section 412.2(e)(1), (2), (3), and (5), revised as of October 1, 2003, which in incorporated by reference and will be made available upon request to the Administrative Director. The maximum allowable fees for cost item set forth at 42 C.F.R. §412.2(e)(4), “the acquisition costs of hearts, kidneys, livers, lungs, pancreas, and intestines (or multivisceral organ) incurred by approved transplantation centers,” shall be based on the documented paid cost of procuring the organ or tissue.

(d) Health facilities billing for fees under this section shall present with their bill the name and address of the facility, the facility's Medicare ID number, and the applicable DRG codes. The billings shall include the principal and secondary diagnoses and surgical procedures. They shall also set forth the patient characteristics, including the DRG weight, the charges, the costs for new technology, and the length of stay.

(e) Cost Outlier cases. Inpatient services for cost outlier cases, shall be reimbursed as follows:

(1) Step 1: Determine the Inpatient Hospital Fee Schedule maximum payment amount (DRG weight x 1.2 x hospital specific composite factor).

(2) Step 2: Determine costs. Costs = (total billed charges x total cost-to-charge ratio).

(3) Step 3: Determine outlier threshold. Outlier threshold = (Inpatient Hospital Fee Schedule payment amount + hospital specific outlier factor + any new technology pass-through payment determined under Section 9789.22(g)).

(4) If costs exceed the outlier threshold, the case is a cost outlier case and the admission is reimbursed at the Inpatient

Hospital Fee Schedule payment amount + new technology pass-through payment determined under Section 9789.22(g) + (0.8 y (costs - cost outlier threshold)).

(5) For purposes of determining whether a case qualifies as a cost outlier case under this subdivision, charges for implantable hardware and/or instrumentation reimbursed under subsection (f) is excluded from the calculation of costs. If an admission for DRGs 496, 497, 498, 519, 520, 531 and 532 qualifies as a cost outlier case, any implantable hardware and/or instrumentation shall be separately reimbursed under subsection (f).

(f) Implantable medical devices, hardware, and instrumentation for DRGs 496, 497, 498, 519, 520, 531 and 532 shall be separately reimbursed at the provider's documented paid cost, plus an additional 10% of the provider's documented paid cost, net of discounts and rebates, not to exceed a maximum of $250.00, plus any sales tax and/or shipping and handling charges actually paid. For purposes of this subdivision, a device is an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar related article, including a component part, or accessory which is: (1) recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them; (2) intended for use in the cure, mitigation, treatment, or prevention of disease; or (3) intended to affect the structure or any function of the body, and which does not achieve any of its primary intended purposes through chemical action within or on the body and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.

(g) “New technology pass-through”: Additional payments will be allowed for new medical services and technologies as provided by CMS and set forth in Title 42, Code of Federal Regulations Sections 412.87 (effective September 7, 2001 and revised as of October 1, 2003), Section 412.88 (effective September 7, 2001 and amended August 1, 2002 and August 1, 2003 and revised as of October 1, 2003), which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(h) Sole Community Hospitals: If a hospital meets the criteria for sole community hospitals, under Title 42, Code of Federal Regulations §412.92(a), effective October 1, 2002 and revised as of October 1, 2003, and has been classified by CMS as a sole community hospital, its payment rates are determined under Title 42, Code of Federal Regulations § 412.92(d), effective October 1, 2002 and as revised as of October 1, 2003, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(i) Transfers

(1) Inpatient services provided by a health facility transferring an inpatient to another hospital are exempt from the maximum reimbursement formula set forth in subdivision (a). Maximum reimbursement for inpatient medical services of a health facility transferring an inpatient to another hospital shall be a per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under Title 8, California Code of Regulations §9789.22(a). However, the first day of the stay in the transferring hospital shall be reimbursed at twice the per diem amount. The per diem rate is determined by dividing the maximum reimbursement as determined under Title 8, California Code of Regulations §9789.22(a) by the average length of stay for that specific DRG. However, if an admission to a health facility transferring a patient is exempt from the maximum reimbursement formula set forth in subdivision (a) because it satisfies one or more of the requirements of Title 8, California Code of Regulations §9789.22(j), this subdivision shall not apply. Inpatient services provided by the hospital receiving the patient shall be reimbursed under the provisions of Title 8, California Code of Regulations §9789.22(a).

(2) Post-acute care transfers exempt from the maximum reimbursement set forth in subdivision (a).

(A) When an acute care patient is discharged to a post-acute care provider which is a rehabilitation hospital or distinct part rehabilitation unit of an acute care hospital or a long-term hospital, and the patient's discharge is assigned to one of the following qualifying DRGs: 12, 14, 24, 25, 89, 90, 113, 121, 122, 130, 131, 236, 239, 243, 263, 264, 277, 278, 296, 297, 320, 321, 429, 462, 483, or 468; payment to the transferring hospital shall be made as set forth in subdivision (i)(1) of this section.

(B) When an acute care patient is discharged to a post-acute care provider and the patient's discharge is assigned to one of the following qualifying DRGs 209, 210 or 211, the payment to the transferring hospital is 50% of the amount

paid under subdivision (a) of this section, plus 50% of the per diem, set forth in subdivision (i)(1) for each day, up to the full DRG amount.

(j) The following are exempt from the maximum reimbursement formula set forth in subdivision (a) and are paid on a reasonable cost basis.

(1) Critical access hospitals;

(2) Children's hospitals that are engaged in furnishing services to inpatients who are predominantly individuals under the age of 18.

(3) Cancer hospitals as defined by Title 42, Code of Federal Regulations, Section 412.23(f), effective date October 1, 2002 and as revised as of October 1, 2003, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(4) Veterans Administration hospitals.

(5) Long term care hospitals as defined by Title 42, Code of Federal Regulations, Section 412.23(e), effective date October 1, 2002 and as revised as of October 1, 2003, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(6) Rehabilitation hospital or distinct part rehabilitation units of an acute care hospital or a psychiatric hospital or distinct part psychiatric unit of an acute care hospital.

(7) The cost of durable medical equipment provided for use at home is exempt from this Inpatient Hospital Fee Schedule. The cost of durable medical equipment shall be paid pursuant to Section 9789.60.

(8) Out of state hospitals.

(k) A health facility that is not listed on the Medicare Cost Report should notify the Administrative Director and provide in writing the following information: OSHPD Licensure number, Medicare provider number, physical location, number of beds, and, if applicable, avearage FTE residents in approved training programs. If a hospital has been in operation for more than one year, information should also be provided on the precentage of inpatient days attributable to Medicaid patients.

(l) Any health care facility that believes its composite factor or hospital specific outlier factor was erroneously determined because of an error in tabulating data may request the Administrative Director for a re-determination of its composite factor or hospital specific outlier factor. Such requests shall be in writing, shall state the alleged error, and shall be supported by written documentation. Within 30 days after receiving a complete written request, the Administrative Director shall make a redetermination of the composite factor or hospital specific outlier factor or reaffirm the published factor.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1, 5307.3 and 5318, Labor Code. Reference: Sections 4600, 4603.2, 5307.1 and 5318, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of section, transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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New query

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§9789.23. Hospital Composite Factors and Hospital Specific Outlier Factors.

Hospital Composite Factors and Hospital Specific Outlier Factors. (doc) (pdf)

Full Payment Impact File (impfile04zip) at http://www.cms.gov/providers/hipps/ippsputs.asp (Section 9789.23 reflects teh modifications of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §§402, 402 and 502, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

Record Layout at http://cms.hhs.gov/providers/hipps/impact_rcd_lay.pdf.

Composite Rate (in italics) reflects Sole Community Hospital adjustment

NOTE

Authority cited: Sections 133, 4603.5, 5307.1, 5307.3 and 5318, Labor Code. Reference: Sections 4600, 4603.2, 5307.1 and 5318, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of section heading and repealer and new section, transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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New query

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§9789.24. Diagnostic Related Groups, Relative Weights, Geometric Mean Length of Stay.

Diagnostic Related Groups, Relative Weights, Geometric Mean Length of Stay (doc) (pdf)

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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§9789.30. Hospital Outpatient Departments and Ambulatory Surgical Centers - Definitions.

(a) “Adjusted Conversion Factor” means the CMS' conversion factor for 2003 of $52.151 x the market basket inflation factor of 1.034 x (0.4 + (0.6 x wage index)).

(b) “Ambulatory Payment Classifications (APC)” means the Centers for Medicare & Medicaid Services' (CMS) list of ambulatory payment classifications of hospital outpatient services.

(c) “Ambulatory Surgical Center (ASC)” means any surgical clinic as defined in the California Health and Safety Code Section 1204, subdivision (b)(1), any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act, or any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4.

(d) “Annual Utilization Report of Specialty Clinics” means the Annual Utilization Report of Clinics that is filed by February 15 of each year with the Office of Statewide Health Planning and Development by the ASCs as required by Section 127285 and Section 1216 of the Health and Safety Code.

(e) “APC Payment Rate” means CMS' hospital outpatient prospective payment system rate for Calendar Year 2004 as set forth in the Federal Register on November 7, 2003, Volume 68, No. 216, Addendum B, pages 63488 through 63655 conformed to comply with CMS-1471-CN, Federal Register, Volume 68, No. 250 (December 31, 2003), pages 75442 through 75445, and CMS-1371-IFC, Federal Register, Volume 69, No. 3 (January 6, 2004), pages 820 through 844.

(f) “APC Relative Weight” means CMS' APC relative weight as set forth in CMS' hospital outpatient prospective payment system for the Calendar Year 2004 as set forth in the Federal Register on November 7, 2003, Volume 68, No. 216, Addendum B, pages 63488 through 63655 conformed to comply with CMS-1471-CN, Federal Register, Volume 68, No. 250 (December 31, 2003), pages 75442 through 75445, and CMS-1371-IFC, Federal Register, Volume 69, No. 3 (January 6, 2004), pages 820 through 844.

(g) “CMS” means the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.

(h) “Cost to Charge Ratio for ASC” means the ratio of the facility's total operating costs to total gross charges during the preceding calendar year.

(i) “Cost to Charge Ratio for Hospital Outpatient Department” means the hospital cost-to-charge used by the Medicare fiscal intermediary to determine high cost outlier payments.

(j) “HCPCS” means CMS' Healthcare Common Procedure Coding System, which describes products, supplies, procedures and health professional services and includes, the American Medical Associations (AMA's) Physician “Current Procedural Terminology”, Fourth Edition (CPT-4) codes, alphanumeric codes, and related modifiers.

(k) “HCPCS Level I Codes” are the AMA's CPT-4 codes and modifiers for professional services and procedures.

(l) “HCPCS Level II Codes” are national alphanumeric codes and modifiers maintained by CMS for health care products and supplies, as well as some codes for professional services not included in the AMA's CPT-4.

(m) “Health facility” means any facility as defined in Section 1250 of the Health and Safety Code.

(n) “Hospital Outpatient Department” means any hospital outpatient department of a health facility as defined in the California Health and Safety Code Section 1250 and any hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act.

(o) “Hospital Outpatient Department Services” means services furnished by any health facility as defined in the California Health and Safety Code Section 1250 and any hospital that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act to a patient who has not been admitted as an inpatient but who is registered as an outpatient in the records of the hospital.

(p) “Market Basket Inflation Factor” means 3.4%, the market basket percentage increase determined by CMS for FY 2004, as set forth in the Federal Register on August 1, 2003, Volume 68, at page 45346.

(q) “Outpatient Prospective Payment System (OPPS)” means Medicare's payment system for outpatient services at hospitals. These outpatient services are classified according to a list of ambulatory payment classifications (APCs).

(r) “Total Gross Charges” means the facility's total usual and customary charges to patients and third-party payers before reductions for contractual allowances, bad debts, courtesy allowances and charity care.

(s) “Total Operating Costs” means the direct cost incurred in providing care to patients. Included in operating cost are: salaries and wages, rent or mortgage, employee benefits, supplies, equipment purchase and maintenance, professional fees, advertising, overhead, etc. It does not include start up costs.

(t) “Wage Index” means CMS' wage index for urban, rural and hospitals that are reclassified as described in CMS' 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda H through J, pages 63682 through 63690.

(u) “Workers' Compensation Multiplier” means the 120% Medicare multiplier required by Labor Code Section 5307.1, or the 122% multiplier that includes an extra 2% reimbursement for high cost outlier cases.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of subsections (d)-(f), transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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§9789.31. Hospital Outpatient Departments and Ambulatory Surgical Centers - Adoption of Standards.

(a) The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda A through J, pages 63478 through 63690 (CMS-1471-FC), as changed by CMS-1471-CN, Federal Register, Volume 68, No. 250 (December 31, 2003), pages 75442 through 75445, and CMS-1371-IFC, Federal Register, Volume 69, No. 3 (January 6, 2004), pages 820 through 844. See http://www.cms.hhs.gov/regulations/hopps/. The payment system includes:

(1) Addendum A “List of Ambulatory Payment Classifications (APCs) with Status Indicators, Relative Weights, Payment Rates, and Copayment Amounts Calendar Year 2004.”

(2) Addendum B “Payment Status by HCPCS Code and Related Information Calendar Year 2004.”

(3) Addendum D1 “Payment Status Indicators for Hospital Outpatient Prospective Payment System.”

(4) Addendum D2 “Code Conditions.”

(5) Addendum E “CPT Codes Which Would Be Paid Only As Inpatient Procedures.”

(6) Addendum H “Wage Index For Urban Areas”

(7) Addendum I “Wage Index For Rural Areas”

(8) Addendum J “Wage Index For Hospitals That Are Reclassified.”

(b) The Administrative Director incorporates by reference the American Medical Associations' Physician “Current Procedural Terminology,” 2004 Edition.

(c) The Administrative Director incorporates by reference CMS' 2004 Alphanumeric “Healthcare Common Procedure Coding System (HCPCS).”

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of subsection (a), transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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§9789.32. Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule - Applicability.

(a) Sections 9789.30 through 9789.38 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered on or after July 1, 2004. For purposes of this section, emergency room visits shall be defined by CPT codes 99281-99285 and surgical procedures shall be defined by CPT codes 10040-69990. A facility fee is payable only for the specified emergency room and surgical codes and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit or surgical procedure. A supply, drug, device, blood product and biological is considered an integral part of an emergency room visit or surgical procedure if:

(1) the item has a status code N and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or,

(2) the item is furnished in conjunction with an emergency room visit or surgical procedure and has been assigned Status Code G, H or K.

Payment for other services furnished in conjunction with a surgical procedure or emergency room visit shall be in accordance with subdivision (c) of this Section.

(b) Sections 9789.30 through 9789.38 apply to any hospital outpatient department as defined in Section 9789.30(n) and any hospital outpatient department that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act and any ASC as defined in the California Health and Safety Code Section 1204, subdivision (b)(1), any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. SEC. 1395 et seq.) of the federal Social Security Act, and any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4, performing procedures and services on an outpatient basis.

(c) The maximum allowable fees for services, drugs and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in (a) for a facility fee payment and are not bundled in the APC payment rate for a surgical service or emergency room visit will be determined as follows:

(1) The maximum allowable fees for professional medical services which are performed by physicians and other licensed health care providers shall be paid according to Section 9789.10 and Section 9789.11.

(2) The maximum allowable fees for organ acquisition costs and corneal tissue acquisition costs shall be based on the documented paid cost of procuring the organ or tissue.

(3) The maximum allowable fee for drugs not otherwise covered by a Medicare fee schedule payment for facility services shall be 100% of the fee prescribed by Medi-Cal pursuant to Labor Code Section 5307.1 subdivision (a), or,

where applicable, Section 9789.40.

(4) The maximum allowable fee for clinical diagnostic tests shall be determined according to Section 9789.50.

(5) The maximum allowable fees for non-surgical ancillary services with a status code indicator “X” shall be determined according to Section 9789.10 and Section 9789.11.

(6) The maximum allowable fee for durable medical equipment, prosthetics and orthotics shall be determined according to Section 9789.60.

(7) The maximum allowable fee for ambulance service shall be determined according to Section 9789.70.

(d) Only hospitals may charge or collect a facility fee for emergency room visits. Only hospital outpatient departments and ambulatory surgical centers as defined in Section 9789.30(n) and Section 9789.30(c) may charge or collect a facility fee for surgical services provided on an outpatient basis.

(e) Hospital outpatient departments and ambulatory surgical centers shall not be reimbursed for procedures on the inpatient only list, Section 9789.31(a)(5), Addendum E, except that pre-authorized services rendered are payable at the pre-negotiated fee arrangement. The pre-authorization must be provided by an authorized agent of the claims administrator to the provider. The fee agreement and pre-authorization must be memorialized in writing prior to performing the medical services.

(f) Critical access hospitals and hospitals that are excluded from acute PPS are exempt from this fee schedule.

(g) Out of state hospital outpatient departments and ambulatory surgical centers are exempt from this fee schedule.

(h) Hospital outpatient departments and ambulatory surgical centers billing for facility fees and other services under this Section shall present with their bill the name and physical address of the facility, the facility's Medicare Provider Number or UPIN (or, in the absence of the Medicare number, the OSHPD Facility Number). The bill shall include the dates of service, the diagnosis and current HCPCS codes and charges for each billed service, including HCPCS codes for any items and services that are packaged into the APC payment for a significant procedure.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of section, transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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§9789.33. Hospital Outpatient Departments and Ambulatory Surgical Facilities Fee Schedule - Determination of Maximum Reasonable Fee.

(a) For Services rendered on or after July 1, 2004, the maximum allowable payment for outpatient facility fees for hospital emergency room services or for surgical services performed at a hospital outpatient department or at an ambulatory surgical center shall be determined based on the following. The 1.22 factor shall be used in lieu of an additional payment for high cost outlier cases.

(1) CTP codes 99281-99285 and CPT codes 10040-69990 with status code indicators “S”, “T”, “X” or “V”:

(APC relative weight x $52.151) x (.40 + .60 x applicable wage index) x inflation factor of 1.034 x 1.22

(A) Table A in Section 9789.34 contains an “adjusted conversion factor” which incorporates the standard conversion factor, wage index and inflation factor. The maximum payment rate for ASCs and non-listed hospitals can be determined as follows:

APC relative weight x adjusted conversion factor x 1.22

(B) Table B in Section 9789.35 contains an “adjusted conversion factor” which incorporates the standard conversion factor, wage index and inflation factor. The maximum payment rate for the listed hospitals can be determined as follows:

APC relative weight x adjusted conversion factor x 1.22

(2) Procedure codes for drugs and biologicals with status code indicator “G”:

APC payment rate x 1.22

(3) Procedure codes for devices with status code indicator “H”:

Documented paid costs, net of discounts and rebates, plus 10% not to exceed $250.00, plus any sales tax and/or shipping and handling charges actually paid.

(4) Procedure codes for drugs and biologicals with status code indicator “K”:

APC payment rate x 1.22

(b) Alternative payment methodology. In lieu of the maximum allowable fees set forth under (a), the maximum allowable fees for a facility meeting the requirements in subdivisions (c)(1) through (c)(5) will be determined as

follows:

(1) Standard payment:

(A) CTP codes 99281-99285 and CPT codes 10040-69990 with status code indicators “S”, “T”, “X” or “V”:

(APC relative weight x $52.151) x (.40 + .60 x applicable wage index) x inflation factor of 1.034 x 1.20

(B) Procedure codes for drugs and biologicals with status code indicator “G”:

APC payment rate x 1.20

(C) Procedure codes for devices with status code indicator “H”:

Documented paid costs, net of discounts and rebates, plus 10% not to exceed $250.00, plus any sales tax and/or shipping and handling charges actually paid.

(D) Procedure codes for drugs and biologicals with status code indicator “K”

APC payment rate x 1.20

(2) Additional payment for high cost outlier case:

[(Facility charges x cost-to-charge ratio) - (standard payment x 2.6)] x .50

(3) In determining the additional payment, the facility's charges and payment for devices with status code indicator “H” shall be excluded from the computation.

(c) The following requirements shall be met for election of the alternative payment methodology:

(1) A facility seeking to be paid for high cost outlier cases under subdivision 9789.33(b) must file a written election using DWC Form 15 “Election for High Cost Outlier,” contained in Section 9789.37 with the Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient). P.O. Box 8888, San Francisco, CA 94128. The form must be post-marked by March 1 of each year and shall be effective for one year commencing with services furnished on or after April 1 of the year in which the election is made.

(2) The maximum allowable fees applicable to a facility that does not file a timely election satisfying the requirements set forth in this subdivision and Section 9789.37 shall be determined under subdivision (a).

(3) The maximum allowable fees applicable to a hospital that does not participate under the Medicare program shall be determined under subdivision (a).

(4) The cost-to-charge ratio applicable to a hospital participating in the Medicare program shall be the hospital's cost-to-charge ratio used by the Medicare fiscal intermediary to determine high cost outlier payments under 42 C.F.R. § 419.43(d), which is incorporated by reference, as contained in Section 9789.38 Appendix X. The cost-to-charge ratio being used by the intermediary for services furnished on February 15 of the year the election is filed shall be included on the hospital's election form.

(5) The cost-to-charge ratio applicable to an ambulatory surgery center shall be the ratio of the facility's total operating costs to total gross charges during the preceding calendar year. Total Operating Costs are the direct costs incurred in providing care to patients. Included in operating cost are: salaries and wages, rent or mortgage, employee benefits, supplies, equipment purchase and maintenance, professional fees, advertising, overhead, etc. It does not include start up costs. Total gross charges are defined as the facility's total usual and customary charges to all patients and third-party party payers before reductions for contractual allowances, bad debts, courtesy allowances and charity care. The facility's election form, as contained in Section 9789.37 shall include a completed Annual Utilization Report of Specialty Clinics filed with Office of Statewide Health Planning and Development (OSHPD) for the preceding

calendar year, which is incorporated by reference. The facility's election form shall further include the facility's total operating costs during the preceding calendar year, the facility's total gross charges during the preceding calendar year, and a certification under penalty of perjury signed by the Chief Executive Officer and a Certified Public Accountant, as to the accuracy of the information. Upon request from the Administrative Director, an independent audit may be conducted at the expense of the ASC. (Note: While ASCs may not typically file Annual Utilization Report of Specialty Clinics with OSHPD, any ASC applying for the alternative payment methodology must file the equivalent, subject to the Division of Workers' Compensation's audit.) A copy of the Annual Utilization Report of Specialty Clinics may be obtained at OSHPD's website at http://www.oshpd.ca.gov/HID/HID/clinic/util/index.htm#Forms or upon request to the Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box 8888, San Francisco, CA 94128.

(6) Before April 1 of each year the AD shall post a list of those facilities that have elected to be paid under this paragraph and the facility-specific cost-to-charge ratio that shall be used to determine additional fees allowable for high cost outlier cases. The list shall be posted on the Division of Workers' Compensation website: http://www.dir.ca.gov/DWC/dwc_home_page.htm or is available upon request to the Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box 8888, San Francisco, CA 94128.

(d) Any ambulatory surgical center that believes its cost-to-charge ratio in connection with its election to participate in the alternative payment methodology for high cost outlier cases under Section 9789.33(b) was erroneously determined because of error in tabulating data may request the Administrative Director for a re-determination of its cost-to-charge ratio. Such requests shall be in writing, shall state the alleged error, and shall be supported by written documentation. Within 30 days after receiving a complete written request, the Administrative Director shall make a redetermination of the cost-to-charge ratio or reaffirm the published cost-to-charge ratio.

(e) The OPPS rules in 42 C.F.R § 419.44 regarding reimbursement for multiple procedures are incorporated by reference as contained in Section 9789.38 Appendix X.

(f) The OPPS rules in 42 C.F.R. §§ 419.62, 419.64, and 419.66 regarding transitional pass-through payments for innovative medical devices, drugs and biologicals shall be incorporated by reference, as contained in Section 9789.38 Appendix X, except that payment for these items shall be in accordance with subdivisions (a) or (b) as applicable.

(g) The payment determined under subdivisions (a) and (b) include reimbursement for all of the included cost items specified in 42 CFR §419.2(b)(1)-(12), which is incorporated by reference, as contained in Section 9789.38 Appendix X.

(h) The maximum allowable fee shall be determined without regard to the cost items specified in 42 C.F.R. § 419.2(c)(1), (2), (3), (4), and (6), as contained in Section 9789.38 Appendix X. Cost item set forth at 42 C.F.R. § 419.2(c)(5), as contained in Section 9789.38 Appendix X, is payable pursuant to Section 9789.32(c)(1). Cost items set forth at 42 C.F.R. § 419.2(c)(7) and (8), as contained in Section 9789.38 Appendix X, are payable pursuant to Section 9789.32(c)(2).

(i) The maximum allowable fees shall be determined without regard to the provisions in 42 C.F.R. § 419.70.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1, and 5307.3, Labor Code. Reference: Sections 4600, 4603.2, and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of section, transmitted to OAL 4-30-2004 and

filed 6-15-2004 (Register 2004, No. 25).

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§9789.34. Table A.

(See addenda H and I set forth in section 9789.31

9789.34 table (doc) (pdf)

* $52.151 y (.40 + .60 y applicable wage index) y inflation factor of 1.034

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of section, transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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§9789.35. Table B.

(See addenda H, I and J set forth in section 9789.31)

9789.35 table (doc) (pdf)

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment, transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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§9789.36. Update of Rules to Reflect Changes in the Medicare Payment System.

Sections 9789.30 through 9789.38 shall be adjusted to conform to any relevant changes in the Medicare payment schedule, including mid-year changes, no later than 60 days after the effective date of those changes. Updates shall be posted on the Division of Workers' Compensation webpage at http://www.dir.ca.gov/DWC/dwc_home_page.htm. The annual updates to the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule shall be effective every year on January 1.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of section, transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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§9789.37. DWC Form 15 Election for High Cost Outlier.

Election for high cost outlier - DWC form 15 (doc) (pdf)

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

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§9789.38.Appendix X.

The federal regulations as incorporated by reference and/or referred to in Sections 9789.30 through 9789.36 are set forth below in numerical order.

42 C.F.R. § 419.2

Basis of payment.

(a) Unit of payment. Under the hospital outpatient prospective payment system, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the Centers for Medicare & Medicaid Services Common Procedure Coding System (HCPCS). The prospective payment rate for each service or procedure for which payment is allowed under the hospital outpatient prospective payment system is determined according to the methodology described in subpart C of this part. The manner in which the Medicare payment amount and the beneficiary copayment amount for each service or procedure are determined is described in subpart D of this part.

(b) Determination of hospital outpatient prospective payment rates: Included costs. The prospective payment system establishes a national payment rate, standardized for geographic wage differences, that includes operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis. In general, these costs include, but are not limited to

(1) Use of an operating suite, procedure room, or treatment room;

(2) Use of recovery room;

(3) Use of an observation bed;

(4) Anesthesia, certain drugs, biologicals, and other pharmaceuticals; medical and surgical supplies and equipment; surgical dressings; and devices used for external reduction of fractures and dislocations;

(5) Supplies and equipment for administering and monitoring anesthesia or sedation;

(6) Intraocular lenses (IOLs);

(7) Incidental services such a venipuncture;

(8) Capital-related costs;

(9) Implantable items used in connection with diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;

(10) Durable medical equipment that is implantable;

(11) Implantable prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of these devices; and;

(12) Costs incurred to procure donor tissue other than corneal tissue.

(c) Determination of hospital outpatient prospective payment rates: Excluded costs. The following costs are excluded from the hospital outpatient prospective payment system.

(1) The costs of direct graduate medical education activities as described in §413.86 of this chapter.

(2) The costs of nursing and allied health programs as described in §413.86 of this chapter.

(3) The costs associated with interns and residents not in approved teaching programs as described in §415.202 of this chapter.

(4) The costs of teaching physicians attributable to Part B services for hospitals that elect cost-based reimbursement for teaching physicians under §415.160.

(5) The reasonable costs of anesthesia services furnished to hospital outpatients by qualified nonphysician anesthetists (certified registered nurse anesthetists and anesthesiologists' assistants) employed by the hospital or obtained under arrangements, for hospitals that meet the requirements under §412.113(c) of this chapter.

(6) Bad debts for uncollectible deductibles and coinsurances as described in §413.80(b) of this chapter.

(7) Organ acquisition costs paid under Part B.

(8) Corneal tissue acquisition costs.

42 C.F.R. § 419.32

Calculation of prospective payment rates for hospital outpatient services.

(a) Conversion factor for 1999. CMS calculates a conversion factor in such a manner that payment for hospital outpatient services furnished in 1999 would have equaled the base expenditure target calculated in § 419.30, taking into account APC group weights and estimated service frequencies and reduced by the amounts that would be payable in 1999 as outlier payments under § 419.43(d) and transitional pass-through payments under § 419.43(e).

(b) Conversion factor for calendar year 2000 and subsequent years. (1) Subject to paragraph (b)(2) of this section, the conversion factor for a calendar year is equal to the conversion factor calculated for the previous year adjusted as follows:

(i) For calendar year 2000, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point.

(ii) For calendar year 2001 --

(A) For services furnished on or after January 1, 2001 and before April 1, 2001, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point; and

(B) For services furnished on or after April 1, 2001 and before January 1, 2002, by the hospital inpatient market basket

percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act, and increased by a transitional percentage allowance equal to 0.32 percent.

(iii) For the portion of calendar year 2002 that is affected by these rules, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point, without taking into account the transitional percentage allowance referenced in § 419.32(b)(ii)(B).

(iv) For calendar year 2003 and subsequent years, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act.

(2) Beginning in calendar year 2000, CMS may substitute for the hospital inpatient market basket percentage in paragraph (b) of this section a market basket percentage increase that is determined and applied to hospital outpatient services in the same manner that the hospital inpatient market basket percentage increase is determined and applied to inpatient hospital services.

(c) Payment rates. The payment rate for services and procedures for which payment is made under the hospital outpatient prospective payment system is the product of the conversion factor calculated under paragraph (a) or paragraph (b) of this section and the relative weight determined under § 419.31(b).

(d) Budget neutrality.

(1) CMS adjusts the conversion factor as needed to ensure that updates and adjustments under § 419.50(a) are budget neutral.

(2) In determining adjustments for 2004 and 2005, CMS will not take into account any additional expenditures per section 1833(t)(14) of the Act that would not have been made but for enactment of section 621 of the Medicare Prescription Drug, Improvement, and Mordernization Act of 2003.

42 C.F.R. § 419.43

Adjustments to national program payment and beneficiary copayment amounts.

(a) General rule. CMS determines national prospective payment rates for hospital outpatient department services and determines a wage adjustment factor to adjust the portion of the APC payment and national beneficiary copayment amount attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner.

(b) Labor-related portion of payment and copayment rates for hospital outpatient services. CMS determines the portion of hospital outpatient costs attributable to labor and labor-related costs (known as the “labor-related portion” of hospital outpatient costs) in accordance with § 419.31(c)(1).

(c) Wage index factor. CMS uses the hospital inpatient prospective payment system wage index established in accordance with part 412 of this chapter to make the adjustment referred to in paragraph (a) of this section.

(d) Outlier adjustment -- (1) General rule. Subject to paragraph (d)(4) of this section, CMS provides for an additional payment for a hospital outpatient service (or group of services) not excluded under paragraph (f) of this section for which a hospital's charges, adjusted to cost, exceed the following:

(i) A fixed multiple of the sum of --

(A) The applicable Medicare hospital outpatient payment amount determined under § 419.32(c), as adjusted under § 419.43 (other than for adjustments under this paragraph (d) or paragraph (e) of this section); and

(B) Any transitional pass-through payment under paragraph (e) of this section.

(ii) At the option of CMS, a fixed dollar amount.

(2) Amount of adjustment. The amount of the additional payment under paragraph (d)(1) of this section is determined by CMS and approximates the marginal cost of care beyond the applicable cutoff point under paragraph (d)(1) of this section.

(3) Limit on aggregate outlier adjustments -- (i) In general. The total of the additional payments made under this paragraph (d) for covered hospital outpatient department services furnished in a year (as estimated by CMS before the beginning of the year) may not exceed the applicable percentage specified in paragraph (d)(3)(ii) of this section of the total program payments (sum of both the Medicare and beneficiary payments to the hospital) estimated to be made under this part for all hospital outpatient services furnished in that year. If this paragraph is first applied to less than a full year, the limit applies only to the portion of the year.

(ii) Applicable percentage. For purposes of paragraph (d)(3)(i) of this section, the term “applicable percentage” means a percentage specified by CMS up to (but not to exceed) --

(A) For a year (or portion of a year) before 2004, 2.5 percent; and

(B) For 2004 and thereafter, 3.0 percent.

(4) Transitional authority. In applying paragraph (d)(1) of this section for hospital outpatient services furnished before January 1, 2002, CMS may --

(i) Apply paragraph (d)(1) of this section to a bill for these services related to an outpatient encounter (rather than for a specific service or group of services) using hospital outpatient payment amounts and transitional pass-through payments covered under the bill; and

(ii) Use an appropriate cost-to-charge ratio for the hospital or CMHC (as determined by CMS), rather than for specific departments within the hospital.

(e) Budget neutrality. CMS establishes payment under paragraph (d) of this section in a budget-neutral manner excluding services and groups specified in paragraph (f) of this section.

(f) Excluded services and groups. Drugs and biologicals that are paid under a separate APC and devices of branchytherapy, consisting of a seed or seeds (including radioactive source) are excluded from qualification for outlier payments.

42 C.F.R. § 419.44

(a) Multiple surgical procedures. When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on --

(1) The full amounts for the procedure with the highest APC payment rate; and

(2) One-half of the full program and the beneficiary payment amounts for all other covered procedures.

(b) Terminated procedures. When a surgical procedure is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary copayment amount are based on --

(1) The full amounts if the procedure is discontinued after the induction of anesthesia or after the procedure is started; or

(2) One-half of the full program and the beneficiary coinsurance amounts if the procedure is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed but before anesthesia is

induced.]

42 C.F.R. § 419.62

Transitional pass-through payments: General rules.

(a) General. CMS provides for additional payments under §§ 419.64 and 419.66 for certain innovative medical devices, drugs, and biologicals.

(b) Budget neutrality. CMS establishes the additional payments under §§ 419.64 and 419.66 in a budget neutral manner.

(c) Uniform prospective reduction of pass-through payments. (1) If CMS estimates before the beginning of a calendar year that the total amount of pass-through payments under §§ 419.64 and 419.66 for the year would exceed the applicable percentage (as described in paragraph (c)(2) of this section) of the total amount of Medicare payments under the outpatient prospective payment system. CMS will reduce, pro rata, the amount of each of the additional payments under §§ 419.64 and 419.66 for that year to ensure that the applicable percentage is not exceeded.

(2) The applicable percentages are as follows:

(i) For a year before CY 2004, the applicable percentage is 2.5 percent.

(ii) For 2004 and subsequent years, the applicable percentage is a percentage specified by CMS up to (but not to exceed) 2.0 percent.

(d) CY 2002 incorporated amount. For the portion of CY 2002 affected by these rules, CMS incorporated 75 percent of the estimated pass-through costs (before the incorporation and any pro rata reduction) for devices into the procedure APCs associated with these devices.

42 C.F.R. § 419.64

Transitional pass-through payments: drugs and biologicals.

(a) Eligibility for pass-through payment. CMS makes a transitional pass-through payment for the following drugs and biologicals that are furnished as part of an outpatient hospital service:

(1) Orphan drugs. A drug or biological that is used for a rare disease or condition and has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act if payment for the drug or biological as an outpatient hospital service was being made on August 1, 2000.

(2) Cancer therapy drugs and biologicals. A drug or biological that is used in cancer therapy, including, but not limited to, a chemotherapeutic agent, an antiemetic, a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, and a bisphosphonate if payment for the drug or biological as an outpatient hospital service was being made on August 1, 2000.

(3) Radiopharmaceutical drugs and biological products. A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine services if payment for the drug or biological as an outpatient hospital service was being made on August 1, 2000.

(4) Other drugs and biologicals. A drug or biological that meets the following conditions:

(i) It was first payable as an outpatient hospital service after December 31, 1996.

(ii) CMS has determined the cost of the drug or biological is not insignificant in relation to the amount payable for the applicable APC (as calculated under § 419.32(c)) as defined in paragraph (b) of this section.

(b) Cost. CMS determines the cost of a drug or biological to be not insignificant if it meets the following requirements:

(1) Services furnished before January 1, 2003. The expected reasonable cost of a drug or biological must exceed 10 percent of the applicable APC payment amount for the service related to the drug or biological.

(2) Services furnished after December 31, 2002. CMS considers the average cost of a new drug or biological to be not insignificant if it meets the following conditions:

(i) The estimated average reasonable cost of the drug or biological in the category exceeds 10 percent of the applicable APC payment amount for the service related to the drug or biological.

(ii) The estimated average reasonable cost of the drug or biological exceeds the cost of the drug or biological portion of the APC payment amount for the related service by at least 25 percent.

(iii) The difference between the estimated reasonable cost of the drug or biological and the estimated portion of the APC payment amount for the drug or biological exceeds 10 percent of the APC payment amount for the related service.

(c) Limited period of payment. CMS limits the eligibility for a pass-through payment under this section to a period of at least 2 years, but not more than 3 years, that begins as follows:

(1) For a drug or biological described in paragraphs (a)(1) through (a)(3) of this section -- August 1, 2000.

(2) For a drug or biological described in paragraph (a)(4) of this section -- the date that CMS makes its first pass-through payment for the drug or biological.

(d) Amount of pass-through payment. (1) Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological as specified in section 1842(o)(1)(A) and (o)(1)(D)(i) of the Act is 95 percent of the average wholesale price of the drug or biological minus the portion of the APC payment CMS determines is associated with the drug or biological.

(2) Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological as specified in section 1842(o)(1)(B) and (o)(1)(E)(i) of the act is 85 percent of the average wholesale price, determined as of April 1, 2003, of the drug or biological minus the portion of the APC payment CMS determines is associated with the drug or biological.

42 C.F.R. § 419.66

Transitional pass-through payments: medical devices.

(a) General rule. CMS makes a pass-through payment for a medical device that meets the requirements in paragraph (b) of this section and that is described by a category of devices established by CMS under the criteria in paragraph (c) of this section.

(b) Eligibility. A medical device must meet the following requirements:

(1) If required by the FDA, the device must have received FDA approval or clearance (except for a device that has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA in accordance with §§ 405.207 and 405.211 of this chapter) or another appropriate FDA exemption.

(2) The device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part (as required by section 1862(a)(1)(A) of the Act).

(3) The device is an integral and subordinate part of the service furnished, is used for one patient only, comes in contact with human tissue, and is surgically implanted or inserted whether or not it remains with the patient when the patient is released from the hospital.

(4) The device is not any of the following:

(i) Equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1).

(ii) A material or supply furnished incident to a service (for example, a suture, customized surgical kit, or clip, other than radiological site marker).

(iii) A material that may be used to replace human skin (for example, a biological or synthetic material).

(c) Criteria for establishing device categories. CMS uses the following criteria to establish a category of devices under this section:

(1) CMS determines that a device to be included in the category is not described by any of the existing categories or by any category previously in effect, and was not being paid for as an outpatient service as of December 31, 1996.

(2) CMS determines that a device to be included in the category has demonstrated that it will substantially improve the diagnosis or treatment of an illness or injury or improve the functioning of a malformed body part compared to the benefits of a device or devices in a previously established category or other available treatment.

(3) Except for medical devices identified in paragraph (e) of this section, CMS determines the cost of the device is not insignificant as described in paragraph (d) of this section.

(d) Cost criteria. CMS considers the average cost of a category of devices to be not insignificant if it meets the following conditions:

(1) The estimated average reasonable cost of devices in the category exceeds 25 percent of the applicable APC payment amount for the service related to the category of devices.

(2) The estimated average reasonable cost of the devices in the category exceeds the cost of the device-related portion of the APC payment amount for the related service by at least 25 percent.

(3) The difference between the estimated average reasonable cost of the devices in the category and the portion of the APC payment amount for the device exceeds 10 percent of the APC payment amount for the related service.

(e) Devices exempt from cost criteria. The following medical devices are not subject to the cost requirements described in paragraph (d) of this section, if payment for the device was being made as an outpatient service on August 1, 2000:

(1) A device of brachytherapy.

(2) A device of temperature-monitored cryoablation.

(f) Identifying a category for a device. A device is described by a category, if it meets the following conditions:

(1) Matches the long descriptor of the category code established by CMS.

(2) Conforms to guidance issued by CMS relating to the definition of terms and other information in conjunction with the category descriptors and codes.

(g) Limited period of payment for devices. CMS limits the eligibility for a pass-through payment established under this section to a period of at least 2 years, but not more than 3 years beginning on the date that CMS establishes a category of devices.

(h) Amount of pass-through payment. Subject to any reduction determined under § 419.62(b), the pass-through

payment for a device is the hospital's charge for the device, adjusted to the actual cost for the device, minus the amount included in the APC payment amount for the device.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of section, transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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New query

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§9789.40. Pharmacy

(a) The maximum reasonable fee for pharmaceuticals and pharmacy services rendered after January 1, 2004 is 100% of the reimbursement prescribed in the relevant Medi-Cal payment system, including the Medi-Cal professional fee for dispensing. Medi-Cal rates will be made available on the Division of Workers' Compensation's Internet Website (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:

Division of Workers' Compensation
(Attention: OMFS - Pharmacy)
P.O. Box 420603
San Francisco, CA 94142.

(b) For a pharmacy service or drug that is not covered by a Medi-Cal payment system, the maximum reasonable fee paid shall not exceed the drug cost portion of the fee determined in accordance with this subdivision, plus $7.25 professional fee for dispensing or $8.00 if the patient is in a skilled nursing facility or in an intermediate care facility. The maximum fee shall include only a single professional dispensing fee for dispensing for each dispensing of a drug.

(1) If the National Drug Code for the drug product as dispensed is not in the Medi-Cal database, and the National Drug Code for the underlying drug product from the original labeler appears in the Medi-Cal database, then the maximum fee shall be the drug cost portion of the reimbursement allowed pursuant to section 14105.45 of the Welfare and Institutions Code using the National Drug Code for the underlying drug product from the original labeler as it appears in the Medi-Cal database, calculated on a per unit basis, plus the professional fee allowed by subdivision (b) of this section.

(2) If the National Drug Code for the drug product as dispensed is not in the Medi-Cal database and the National Drug Code for the underlying drug product from the original labeler is not in the Medi-Cal database, then the maximum fee shall be 83 percent of the average wholesale price of the lowest priced therapeutically equivalent drug, calculated on a per unit basis, plus the professional fee allowed by subdivision (b) of this section.

(c) For purposes of this section:

(1) "therapeutically equivalent drugs" means drugs that have been assigned the same Therapeutic Equivalent Code starting with the letter "A" in the Food and Drug Administration's publication "Approved Drug Products with Therapeutic Equivalence Evaluations" ("Orange Book".) The Orange Book any be accessed through the Food and Drug Administration's website:http:// www.fda.gov/cder/orange/default.htm.;

(2) "National Drug Code for the underlying drug product from the original labeler" means the National Drug Code of the drug product actually utilized by the repackager in producing the repackaged product.

(d) The changes made to this Section in February, 2007, shall be applicable to all pharmaceuticals dispensed or provided on or after March 1, 2007.

<General Materials (GM) - References, Annotations, or Tables>

Note: Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including redesignation of existing section as subsection (a) and new subsection (b), transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

3. Amendment of subsections (a) and (b) and new subsections (b)(1)-(d) filed 2-28-2007; operative 2-28-2007. Submitted to OAL for printing purposes only pursuant to Government Code section 11343.8, as exempt from the APA and OAL review pursuant to Government Code section 11340.9(g) (Register 2007, No.9).

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New query

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§9789.50. Pathology and Laboratory.

(a) Effective for services after January 1, 2004, the maximum reasonable fees for pathology and laboratory services shall not exceed one hundred twenty (120) percent of the rate for the same procedure code in the CMS' Clinical Diagnostic Laboratory Fee Schedule, as established by Sections 1833 and 1834 of the Social Security Act (42 U.S.C. §§ 1395l and 1395m) and applicable to California. The Clinical Diagnostic Laboratory Fee Schedule, which can be found on the CMS Internet Website (http://www.cms.hhs.gov/paymentsystems) is incorporated by reference and will be made available on the Division of Workers' Compensation's Internet Website (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:

DIVISION OF WORKERS' COMPENSATION
(ATTENTION: OMFS)
P.O. BOX 420603
SAN FRANCISCO, CA 94142.

(b) The following procedures in the Special Services and Reports section of the OMFS 2003 will not be valid for services rendered after January 1, 2004: CPT Codes 99000, 99001, 99017, 99019, 99020, 99021, 99026, and 99027.

(c) For any pathology and laboratory service not covered by a Medicare payment system, the maximum reasonable fee paid shall not exceed the fee specified in the OMFS 2003.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including new subsection (c), transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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New query

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§9789.60. Durable Medical Equipment, Prosthetics, Orthotics, Supplies.

(a) For services, equipment, or goods provided after January 1, 2004, the maximum reasonable reimbursement for durable medical equipment, supplies and materials, orthotics, prosthetics, and miscellaneous supplies and services shall not exceed one hundred twenty (120) percent of the rate set forth in the CMS' Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule, as established by Section 1834 of the Social Security Act (42 U.S.C. § 1395m) and applicable to California. The DMEPOS Fee Schedule, which can be found on the CMS Internet Website (http://www.cms.hhs.gov/paymentsystems) is incorporated by reference and will be made available on the Division of Workers' Compensation's Internet Website (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:

DIVISION OF WORKERS' COMPENSATION
(ATTENTION: OMFS)
P.O. BOX 420603
SAN FRANCISCO, CA 94142.

(b) The following procedures in the Special Services and Reports section of the OMFS 2003 will not be valid for services rendered after January 1, 2004: CPT Code 99002.

(c) For durable medical equipment, supplies and materials, orthotics, prosthetics, and miscellaneous supplies and services not covered by a Medicare payment system, the maximum reasonable fee paid shall not exceed the fee specified in the OMFS 2003.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of subsection (b) and new subsection (c), transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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New query

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§9789.70. Ambulance Services.

(a) The maximum reasonable fee for ambulance services rendered after January 1, 2004 shall not exceed 120% of the applicable fee for the Calendar Year 2004 set forth in CMS's Ambulance Fee Schedule, which is established pursuant to Section 1834 of the Social Security Act (42 U.S.C. § 1395m) and applicable to California. The Ambulance Fee Schedule, which can be found at the CMS Internet Website http://www.cms.hhs.gov/suppliers/ambulance is incorporated by reference and will be made available on the Division of Workers' Compensation's Internet Website (http://www.dir.ca.gov/DWC/dwc_home_page.htm) or upon request to the Administrative Director at:

DIVISION OF WORKERS' COMPENSATION
(ATTENTION: OMFS)
P.O. BOX 420603
SAN FRANCISCO, CA 94142.

(b) For any ambulance service not covered by a Medicare payment system, the maximum reasonable fee paid shall not exceed the fee specified in the OMFS 2003.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including designation and amendment of first paragraph as subsection (a) and new subsection (b), transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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§9789.80. Skilled Nursing Facility. [Reserved]

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§9789.90. Home Health Care. [Reserved]

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§9789.100. Outpatient Renal Dialysis. [Reserved]

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New query

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§9789.110. Update of Rules to Reflect Changes in the Medicare Payment System.

The OMFS shall be adjusted within 60 days to conform to any relevant changes in the Medicare and Medi-Cal payment systems as required by law. The Administrative Director shall determine the effective date of the change and issue an order informing the public of the change and the effective date. Such order shall be posted on the Division's Internet Website: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 1-2-2004 as an emergency; operative 1-2-2004 (Register 2004, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-3-2004 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-2-2004 order, including amendment of section, transmitted to OAL 4-30-2004 and filed 6-15-2004 (Register 2004, No. 25).

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New query

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§9789.111. Effective Date of Fee Schedule Provisions.

(a) The OMFS regulations for Physician Services (Sections 9789.10-9789.11) are effective for services rendered on or after July 1, 2004. Services rendered after January 1, 2004, but before July 1, 2004 are governed by the “emergency” regulations that were effective on January 2, 2004.

(b) The OMFS regulations for Inpatient Services (Sections 9789.20-9789.24) are effective for inpatient hospital admissions with dates of discharge on or after July 1, 2004. Services for discharges after January 1, 2004, but before July 1, 2004 are governed by the “emergency” regulations that were effective on January 2, 2004. Bills for services with date of admission on or before December 31, 2003 will be reimbursed in accordance with Section 9792.1.

(c) The OMFS regulations for Outpatient Services (Sections 9789.30-9789.38) are effective for services rendered on or after July 1, 2004. Services rendered after January 1, 2004, but before July 1, 2004 are governed by the “emergency” regulations that were effective on January 2, 2004.

(d) The OMFS regulation for pharmacy (Section 9789.40) is effective for services rendered after January 1, 2004.

(e) The OMFS regulation for Pathology and Laboratory (Section 9789.50) is effective for services rendered after January 1, 2004.

(f) The OMFS regulation for Durable Medical Equipment, Prosthetics, Orthotics, Supplies (Section 9789.60) is effective for services rendered after January 1, 2004.

(g) The OMFS regulation for Ambulance Services is effective for services rendered after January 1, 2004.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 6-15-2004; operative 7-1-2004 (Register 2004, No. 25).

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Chapter 4.5. Division of Workers' Compensation
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New query

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§9790. Authority.

The rules and regulations contained in this Article are adopted pursuant to the authority contained in Sections 133, 4603.5, 307.1 and 5307.3 of the California Labor Code.

NOTE: Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New article 5.5 (sections 9790-9792) filed 11-9-77; effective thirtieth day thereafter (Register 77, No. 46).

2. Amendment of section and Note filed 10-7-93; operative 1-1-94 (Register 93, No. 41). This filing is exempt from much of the APA (including OAL review) pursuant to Government Code section 11351.

3. Editorial correction (Register 95, No. 15).

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New query

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§9790.1. Definitions.

(a) “Capital outlier factor” means (California fixed loss cost outlier threshold x geographic adjustment factor x large urban add-on x (capital cost-to-charge ratio to total cost-to-charge ratio)). The geographic adjustment factor is specified in the Federal Register of August 1, 2000 at Vol. 65, page 47126, Table 1a, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. The “large urban add-on” is indicated by the post-reclassification urban/rural location published in the Payment Impact File at positions 229-235. As stated in Title 42, Code of Federal Regulations, Section 412.316(b), as it is in effect on September 29, 2000, the “large urban add-on” is an additional 3% of what would otherwise be payable to the health facility.

(b) “California fixed loss cost outlier threshold” means the factor calculated by adjusting the Medicare fixed loss cost outlier threshold for California workers' compensation inpatient admissions. The California fixed loss cost outlier threshold is $14,500.

(c) “Composite factor” means the factor calculated by the administrative director for a health facility by adding the prospective operating costs and the prospective capital costs for the health facility, excluding the DRG weight and any applicable outlier payment, as determined by the federal Health Care Financing Administration for the purpose of determining reimbursement under Medicare.

(1) Prospective capital costs are determined by the following formula:

Capital standard federal payment rate x capital wage index x large urban add-on x [1 + capital disproportionate share adjustment factor + capital indirect medical education adjustment factor]

The “capital standard federal payment rate” is $382.03 as published by HCFA in the Federal Register of August 1, 2000, at Vol. 65, page 47127, Table 1d, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

The “capital wage index” was published in the Payment Impact File at positions 243-252.

The “large urban add-on” is indicated by the post-reclassification urban/rural location published in the Payment Impact File at positions 229-235. As stated in Title 42, Code of Federal Regulations, Section 412.316(b), as it is in effect on September 29, 2000, the “large urban add-on” is an additional 3% of what would otherwise be payable to the health facility.

The “capital disproportionate share adjustment factor” was published in the Payment Impact File at positions 117-126.

The “capital indirect medical education adjustment factor” (capital IME adjustment) was published in Payment Impact File at positions 202-211.

(2) Prospective operating costs are determined by the following formula:

[(Labor-related national standardized amount x operating wage index) + nonlabor-related national standardized amount] x [1 + operating disproportionate share adjustment factor + operating indirect medical education adjustment]

The “labor-related national standardized amount” is $2,864.19 for large urban areas and $2,818.85 for other areas, as published by the federal Health Care Financing Administration [HCFA] in the Federal Register of August 1, 2000, at Vol. 65, page 47126, Table 1a, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. The “labor-related national standardized amount” is $2,894.99 for large urban area sole community hospitals and $2,849.16 for other areas sole community hospitals, as published by the federal Health Care Financing Administration [HCFA] in the Federal Register of August 1, 2000, at Vol. 65, page 47127, Table 1e, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

The “operating wage index” was published in the Payment Impact File at positions 253-262.

The “nonlabor-related national standardized amount” is $1,164.21 for large urban areas and $1,145.78 for other areas, as published by HCFA in the Federal Register of August 1, 2000, at Vol. 65, page 47126, Table 1a, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. The “nonlabor-related national standardized amount” is $1,176.73 for large urban area sole community hospitals and $1,158.10 for other areas sole community hospitals as published by the federal Health Care Financing Administration [HCFA] in the Federal Register of August 1, 2000, at Vol. 65, page 47127, Table 1e, which document is hereby incorporated by reference and will be made available upon request to the administrative director.

The “operating disproportionate share adjustment factor” was published in the Payment Impact File at positions 127-136.

The “operating indirect medical education adjustment” was published in the Payment Impact File at positions 212-221.

(3) A table of composite factors for each health facility in California is contained in Appendix A to Section 9792.1.

(d) “Costs” means the total billed charges for an admission, excluding non-medical charges such as television and telephone charges, multiplied by the hospital's total cost-to-charge ratio. For DRGs 496 through 500, for purposes of determining whether an admission is a cost outlier, “costs” exclude implantable hardware and/or instrumentation reimbursed under subsection (7) of Section 9792.1.

(e) “Cost-to-charge ratio” means the sum of the hospital specific operating cost-to-charge ratio and the hospital specific capital cost-to-charge ratio. The operating cost-to-charge ratio for each hospital was published in the Payment Impact File at positions 161-168. The capital cost-to-charge ratio for each hospital was published in the Payment Impact File at positions 99-106. A table of hospital specific capital cost-to-charge, operating cost-to-charge and total cost-to-charge ratios for each health facility in California is contained in Appendix A to Section 9792.1.

(f) “Cost outlier case” means a hospitalization for which the hospital's costs, as defined in subdivision (d) above, exceed the Inpatient Hospital Fee Schedule payment amount by the hospital's outlier factor. If costs exceed the cost outlier threshold, the case is a cost outlier case.

(g) “Cost outlier threshold” means the sum of the Inpatient Hospital Fee Schedule payment amount plus the hospital specific outlier factor.

(h) “DRG weight” means the weighting factor for a diagnosis-related group assigned by the Health Care Financing Administration for the purpose of determining reimbursement under Medicare. A table is contained in Appendix B to

Section 9792.1. Appendix B shows DRG weights as assigned by HCFA and, where applicable, “Revised DRG weights” in italics.

(i)(1) “Revised DRG weight” means the product of the DRG weight multiplied by the ratio set forth in subsection (i)(2) for 48 specified DRGs to reflect the different resource usage between the workers' compensation population and the Medicare population.

(2) The ratios that were applied to the DRG weights are contained in the column identified as “DWC Revised Ratio” in Appendix B of Section 9792.1.

(j) “Health facility” means any facility as defined in Section 1250 of the Health and Safety Code.

(k) “Inpatient” means a person who has been admitted to a health facility for the purpose of receiving inpatient services. A person is considered an inpatient when he or she is formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or is transferred to another facility and does not actually remain overnight.

(l) “Inpatient Hospital Fee Schedule payment amount” is that amount determined by multiplying the DRG weight x hospital composite factor x 1.2.

(m) “Labor-related portion” is that portion of operating costs attributable to labor costs, as specified in the Federal Register of August 1, 2000 at Vol. 65, page 47126, Table 1a, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(n) “Medical services” means those goods and services provided pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

(o) “Average length of stay” means the geometric mean length of stay for a diagnosis-related group assigned by the Health Care Financing Administration.

(p) “Operating outlier factor” means ((California fixed loss cost outlier threshold x ((labor-related portion x MSA wage index) + nonlabor-related portion)) x (operating cost-to-charge ratio to total cost-to-charge ratio)). The MSA wage index is specified at Federal Register of August 1, 2000 at Vol. 65, page 47149, Table 4a, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director. The nonlabor-related portion is that portion of operating costs as defined in the Federal Register of August 1, 2000 at Vol. 65, page 47126, Table 1a, which document is hereby incorporated by reference and will be made available upon request to the Administrative Director.

(q) “Outlier factor” means the sum of the capital outlier factor and the operating outlier factor. A table of hospital specific outlier factors for each health facility in California is contained in Appendix A to Section 9792.1.

(r) “Payment Impact File” means the FY 2001 Prospective Payment System Payment Impact File (August 2000 Update) (IMPCTF01.EXE) published by the federal Health Care Financing Administration, which document is hereby incorporated by reference. The description of the file is found at http://www.hcfa.gov/stats/impctf01.doc. The file is accessible through http://www.hcfa.gov/stats/pufiles.htm#ppfexmtp. A paper copy of the Payment Impact File, with explanatory material, is available from the Administrative Director upon request. An electronic copy is available from the Administrative Director at http://www.dir.ca.gov.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 10-7-93; operative 1-1-94 (Register 93, No. 41). This filing is exempt from much of the APA (including OAL review) pursuant to Government Code section 11351.

2. New subsections (a)-(c)(2), subsection relettering, and new subsection (g) filed 12-31-96; operative 12-31-96 pursuant to Government Code section 11343.4(d). Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 97, No. 1).

3. New subsections (a)(1)-(3), amendment of subsections (b) and (c)(2) and new subsection (h) filed 2-23-99; operative 4-1-99 (Register 99, No. 9).

4. Amendment filed 5-30-2001; operative 6-29-2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 23).

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Subchapter 1. Administrative Director--Administrative Rules
Article 5.5. Application of the Official Medical Fee Schedule (Treatment)

New query

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§9791. Services Covered.

Except as provided in this article, the Official Medical Fee Schedule applies to all covered medical services provided, referred or prescribed by physicians (as defined in Section 3209.3 of the Labor Code), regardless of the type of facility in which the medical services are performed, including clinic and hospital-based physicians working on a contract basis. The Schedule shall not apply to inpatient medical services provided by employees of a health facility, medical-legal expenses authorized under Section 4621 of the Labor Code, and medical expenses payable pursuant to Section 9795. Nothing contained in this schedule shall preclude any hospital as defined in subdivisions (a), (b), or (f) of Section 1250 of the Health and Safety Code, or any surgical facility which is licensed under subdivision (b) of Section 1204 of the Health and Safety Code, or any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, or any surgical clinic accredited by the Accreditation Association for Ambulatory Health Care (AAAHC), from charging and collecting a facility fee for the use of the emergency room or operating room of the facility.

NOTE: Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. Amendment of section and new Note filed 10-7-93; operative 1-1-94 (Register 93, No. 41). This filing is exempt from much of the APA (including OAL review) pursuant to Government Code section 11351.

2. Amendment filed 10-11-95; operative 10-11-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 41).

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New query

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§9791.1. Medical Fee Schedule.

The Official Medical Fee Schedule shall include the procedures, procedure numbers, descriptions, instructions, and unit values adopted by the Administrative Director, effective January 1, 1994; as revised for services on or after January 1, 1996; and as thereafter revised and adopted. The Official California Workers' Compensation Medical Fee Schedule (Revised April 1, 1999) is hereby incorporated by reference. An order form for purchasing a copy of the Schedule can be obtained by contacting the Division of Workers' Compensation at the following address:

Division of Workers' Compensation
(Attention: OMFS Order)
P.O. Box 420603
San Francisco, California 94142

NOTE: Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 8-14-81; effective thirtieth day thereafter (Register 81, No. 33).

2. Amendment filed 8-29-84; effective thirtieth day thereafter (Register 84, No. 35).

3. Change without regulatory effect filed 7-11-86; effective upon filing (Register 86, No. 28).

4. Amendment filed 5-18-87; operative 5-18-87 (Register 87, No. 21).

5. Amendment of section and Note filed 10-7-93; operative 1-1-94 (Register 93, No. 41). This filing is exempt from much of the APA (including OAL review) pursuant to Government Code section 11351.

6. Amendment filed 10-11-95; operative 10-11-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 41).

7. Amendment of section incorporating by reference “The Official California Workers' Compensation Medical Fee Schedule” (revised April 1, 1999) filed 2-19-99; operative 4-1-99 (Register 99, No. 8).

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New query

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§9792. Determination of the Fee.

(a) The fee is determined by the use of the Official Medical Fee Schedule as defined in Section 9791.1 of these rules. For services provided on and after January 1, 1994, the conversion factors to be applied to unit values in the schedule are as follows: Determination of the Fee

Evaluation and Management Services Section	$7.15
Medicine Section	$6.15
Surgery Section	$153.00
Radiology Section	$12.50
Pathology Section	$1.50
Anesthesia Section	$34.50

(b) For services in the Evaluation and Management Services Section provided on and after April 1, 1999, the conversion factor to be applied to unit values in the schedule is $8.50.

(c) The conversion factor shall be multiplied by the listed unit value (also known as relative value) of the procedure as set forth in the Official Medical Fee Schedule to establish the reasonable maximum fee. A medical provider or a licensed health care facility may be paid a fee in excess of the reasonable maximum fees if the fee is reasonable, accompanied by itemization, and justified by an explanation of extraordinary circumstances related to the unusual nature of the services rendered; however, in no event shall a physician charge in excess of his or her usual fee.

HISTORY

1. Amendment filed 4-11-79; designated effective 7-1-79 (Register 79, No. 15).

2. Amendment filed 8-14-81; effective thirtieth day thereafter (Register 81, No. 33).

3. Amendment filed 11-5-82; designated effective 1-1-83 (Register 82, No. 45).

4. Amendment filed 11-23-83; effective thirtieth day thereafter (Register 83, No. 48).

5. Amendment filed 8-29-84; effective thirtieth day thereafter (Register 84, No. 35).

6. Editorial correction (Register 84, No. 48).

7. Amendment filed 1-10-85; effective upon filing pursuant to Government Code section 11346.2(d) (Register 85, No. 2).

8. Amendment filed 7-1-87; operative 7-1-87 (Register 87, No. 28).

9. Amendment of section and Note filed 10-7-93; operative 1-1-94 (Register 93, No. 41). This filing is exempt from much of the APA (including OAL review) pursuant to Government Code section 11351.

10. New subsection (a) designator, new subsection (b), and amendment of newly designated subsection (c) filed 2-19-99; operative 4-1-99 (Register 99, No. 8).

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New query

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§9792.1 Payment of Inpatient Services of Health Facilities.

Appendix A. Hospital Composite Factors and Cost to Charge Rations

Appendix B. DRG Weights and Revised Drg Weights 2001 Rates (California revisions shown in italics incorporate the DWC Revised Ratios)

(a) Maximum reimbursement for inpatient medical services shall be determined by multiplying 1.20 by the product of the health facility's composite factor and the applicable DRG weight or revised DRG weight if a revised weight has been adopted by the administrative director. The fee determined under this subdivision shall be a global fee, constituting the maximum reimbursement to a health facility for inpatient medical services not exempted under this section. However, preadmission services rendered by a health facility more than 24 hours before admission are separately reimbursable.

(b) Health facilities billing for fees under this section shall present with their bill the name and address of the facility, the facility's Medicare ID number, and the applicable DRG codes.

(c) The following are exempt from the maximum reimbursement formula set forth in subdivision (a):

(1) Inpatient services for the following diagnoses: Psychiatry (DRGs 424-432), Substance Abuse (DRGs 433-437), Organ Transplants (DRGs 103, 302, 480, 481, 495), Rehabilitation (DRG 462 and inpatient rehabilitation services provided in any rehabilitation center that is authorized by the Department of Health Services in accordance with Title 22, §§70301, 70595 - 70603 of the California Code of Regulations to provide rehabilitation services), Tracheostomies (DRGs 482, 483), and Burns (DRGs 475 and 504-511).

(2) Inpatient services provided by a Level I or Level II trauma center, as defined in Title 22, California Code of Regulations sections 100260, 100261, to a patient with an immediately life threatening or urgent injury.

(3) Inpatient services provided by a health facility for which there is no composite factor.

(4) Inpatient services provided by a health facility located outside the State of California.

(5) The cost of durable medical equipment provided for use at home.

(6) Inpatient services provided by a health facility transferring an inpatient to another hospital. Maximum reimbursement for inpatient medical services of a health facility transferring an inpatient to another hospital shall be a per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under Title 8, California Code of Regulations §9792.1(a). However, the first day of the stay in the transferring hospital

shall be reimbursed at twice the per diem amount. The per diem rate is determined by dividing the maximum reimbursement as determined under Title 8, California Code of Regulations §9792.1(a) by the average length of stay for that specific DRG. However, if an admission to a health facility transferring a patient is exempt from the maximum reimbursement formula set forth in subdivision (a) because it satisfies one or more of the requirements of Title 8, California Code of Regulations §9792.1(c)(1) through (c)(4), subdivision (c)(6) shall not apply. Inpatient services provided by the hospital receiving the patient shall be reimbursed under the provisions of Title 8, California Code of Regulations §9792.1(a).

(7) Implantable hardware and/or instrumentation for DRGs 496 through 500, where the admission occurs on or after April 13, 2001. Implantable hardware and/or instrumentation for DRGs 496 through 500, where the admission occurs on or after April 13, 2001, shall be separately reimbursed at the provider's documented paid cost, plus an additional 10% of the provider's documented paid cost not to exceed a maximum of $250.00, plus any sales tax and/or shipping and handling charges actually paid.

(8) Cost Outlier cases. Inpatient services for cost outlier cases where the admission occurs on or after June 29, 2001, shall be reimbursed as follows:

Step 1: Determine the Inpatient Hospital Fee Schedule payment amount (DRG relative weight x 1.2 x hospital specific composite factor).

Step 2: Determine costs. Costs = (total billed charges x total cost-to-charge ratio).

Step 3: Determine outlier threshold. Outlier threshold = (Inpatient Hospital Fee Schedule payment amount + hospital specific outlier factor).

If costs exceed the outlier threshold, the case is a cost outlier case and the admission is reimbursed at the Inpatient Hospital Fee Schedule payment amount + (0.8 x (costs - cost outlier threshold)).

NOTE: For purposes of determining whether a case qualifies as a cost outlier case under this subsection, implantable hardware and/or instrumentation reimbursed under subsection (8) below is excluded from the calculation of costs. Once an admission for DRGs 496 through 500 qualifies as a cost outlier case, any implantable hardware and/or instrumentation shall be separately reimbursed under subsection (8) below.

(d) Any health care facility that believes its composite factor or hospital specific outlier factor was erroneously determined because of an error in tabulating data may request the Administrative Director for a re-determination of its composite factor or hospital specific outlier factor. Such requests shall be in writing, shall state the alleged error, and shall be supported by written documentation. Within 30 days after receiving a complete written request, the Administrative Director shall make a redetermination of the composite factor or hospital specific outlier factor or reaffirm the published factor.

(e) This section, except as provided in subsections (c)(7) and (c)(8), shall apply to covered inpatient hospital stays for which the day of admittance is on or after April 1, 1999.

(f) Subsections (c)(7) and (c)(8) shall remain in effect only through December 31, 2001, and shall not apply to admissions occurring on or after January 1, 2002.

AN IMPORTANT NOTE CONCERNING SUBSECTIONS (c)(7) AND (c)(8):

Labor Code Section 5318, (as added by Statutes of 2001, chapter 252, effective January 1, 2002,) provides that: “Notwithstanding any other provision of law, the termination date of December 31, 2001, provided in Section 9792.1(f) of Title 8 of the California Code of Regulations shall be extended until the effective date of new regulations adopted by the administrative director, as required by Section 5307.1, providing for the biennial review of the fee schedule for health care facilities.” Sections 9792.1(c)(7) and (c)(8) will therefore remain in effect for admissions on or after January 1, 2002, and will not sunset.

NOTE

Authority cited: Sections 133, 4603.5, 5307.1, 5307.3 and 5318, Labor Code. Reference: Sections 4600, 4603.2, 5307.1 and 5318, Labor Code.

HISTORY

1. New section filed 12-31-96; operative 12-31-96 pursuant to Government Code section 11343.4(d). Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 97, No. 1).

2. Amendment of section and new appendices A-C filed 2-23-99; operative 4-1-99 (Register 99, No. 9).

3. New subsection (c)(8), amendment of subsection (e) and new subsection (f) filed 3-14-2001; operative 4-13-2001. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 2001, No. 22).

4. Amendment of section and repealer and new Appendices A and B filed 5-30-2001; operative 6-29-2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 23).

5. Change without regulatory effect adding final two paragraphs and amending Note filed 12-31-2001 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 1).

Appendix A. Hospital Composite Factors and Cost to Charge Rations

Appendix B. DRG Weights and Revised Drg Weights 2001 Rates (California revisions shown in italics incorporate the DWC Revised Ratios)

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New query

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§9792. Determination of the Fee.

APPENDIX A: Hospital Composite Factors and Cost to Charge Rations

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PROVIDER NUMBER	HOSPITAL NAME	COMPOSITE FACTOR (2001 PAYMENT IMPACT FILE DATA)	CAPITAL COST-TO- CHARGE RATIO	OPERATING COST-TO-CHARGE RATIO	TOTAL COST-TO- CHARGE RATIO	HOSPITAL SPECIFIC OUTLIER FACTOR
50002	ST. ROSE HOSPITAL	7626.1	0.018	0.372	0.390	$ 19,640
50006	ST. JOSEPH HOSPITAL, EUREKA	4303.8	0.036	0.359	0.395	$ 14,357
50007	MILLS PENINSULA MEDICAL CENTER	5732.9	0.035	0.364	0.399	$ 18,837
50008	DAVIES MEDICAL CENTER	6366.3	0.039	0.317	0.356	$ 18,840
50009	QUEEN OF THE VALLEY	5214.8	0.041	0.357	0.398	$ 16,820
50013	ST. HELENA HOSPITAL	5286.9	0.024	0.430	0.454	$ 16,828
50014	SUTTER AMADOR HOSPITAL	4303.8	0.020	0.353	0.373	$ 14,357
50015	NORTHERN INYO HOSPITAL	4346.0	0.028	0.701	0.729	$ 14,357
50016	ARROYO GRANDE COMMUNITY HOSPITAL	4553.8	0.108	0.394	0.502	$ 15,187
50017	MERCY GENERAL HOSPITAL	5765.8	0.022	0.241	0.263	$ 16,548
50018	PACIFIC ALLIANCE MEDICAL CNTR.	8999.4	0.043	0.393	0.436	$ 16,631
50022	RIVERSIDE COMMUNITY	5171.4	0.044	0.337	0.381	$ 15,697
50024	PARADISE VALLEY HOSPITAL	7440.0	0.024	0.360	0.384	$ 16,363
50025	UCSD MEDICAL CENTER	8430.0	0.057	0.321	0.378	$ 16,395
50026	GROSSMONT HOSPITAL	5834.5	0.043	0.318	0.361	$ 16,384
50028	MAD RIVER COMMUNITY HOSPITAL	4303.8	0.026	0.418	0.444	$ 14,357
50029	ST.LUKE MEDICAL CENTER	6514.7	0.031	0.238	0.269	$ 16,637
50030	OROVILLE HOSPITAL	5185.6	0.048	0.495	0.543	$ 14,416
50032	WARRACK HOSPITAL	5159.2	0.033	0.500	0.533	$ 17,216
50033	MOUNT ZION MEDICAL CENTER OF UCSF	8623.8	0.042	0.407	0.449	$ 18,838
50036	MEMORIAL HOSPITAL	4314.7	0.055	0.358	0.413	$ 14,357
50038	SANTA CLARA VALLEY MEDICAL CENTER	9378.9	0.045	0.538	0.583	$ 18,192
50039	ENLOE MEDICAL CENTER	4630.0	0.026	0.434	0.460	$ 14,416
50040	LAC OLIVE VIEW/UCLA MEDICAL CENTER	10003.1	0.033	0.329	0.362	$ 16,628
50042	ST. ELIZABETH COMMUNITY HOSPITAL	4346.0	0.030	0.413	0.443	$ 14,357
50043	SUMMIT MEDICAL CENTER	7556.7	0.016	0.340	0.356	$ 19,640
50045	EL CENTRO REGIONAL MED. CTR.	5940.4	0.021	0.357	0.378	$ 14,381
50046	OJAI VALLEY COMMUNITY HOSPITAL	4494.1	0.059	0.675	0.734	$ 14,992

50047	CALIFORNIA PACIFIC MEDICAL CENTER	7124.8	0.029	0.373	0.402	$ 18,834
50051	ALTA DISTRICT HOSPITAL	4303.8	0.036	0.586	0.622	$ 14,357
50054	SAN GORGONIO MEMORIAL HOSPITAL	4981.7	0.024	0.330	0.354	$ 15,677
50055	ST. LUKES HOSPITAL	8503.5	0.026	0.360	0.386	$ 18,834
50056	ANTELOPE VALLEY HOSPITAL	6281.4	0.043	0.313	0.356	$ 16,639
50057	KAWEAH DELTA HEALTH CARE DISTRICT	5269.1	0.031	0.430	0.461	$ 14,357
50058	GLENDALE MEMORIAL HOSPITAL & HLTH CT	7144.1	0.031	0.278	0.309	$ 16,632
50060	FRESNO COMMUNITY HOSP & MED CENTER	5731.0	0.029	0.337	0.366	$ 14,607
50061	ST. FRANCIS MEDICAL CENTER	4530.4	0.057	0.356	0.413	$ 15,112
50063	QUEEN OF ANGELS - HLLYWD PRES MC	8430.2	0.033	0.296	0.329	$ 16,632
50065	WMC SANTA ANA	7039.7	0.057	0.314	0.371	$ 16,015
50066	BAY HARBOR HOSPITAL	5818.7	0.016	0.302	0.318	$ 16,614
50067	OAK VALLEY DISTRICT HOSPITAL	4468.6	0.029	0.359	0.388	$ 14,907
50068	LINDSAY DISTRICT HOSPITAL	4494.2	0.014	0.487	0.501	$ 14,357
50069	ST. JOSEPH HOSPITAL	5069.0	0.029	0.284	0.313	$ 16,629
50070	KFH- SSF	5729.5	0.039	0.361	0.400	$ 18,838
50071	KFH - SANTA CLARA	7040.9	0.039	0.361	0.400	$ 19,643
50072	KFH - WALNUT CREEK	6149.7	0.039	0.361	0.400	$ 19,643
50073	KFH - VALLEJO	5946.2	0.039	0.361	0.400	$ 19,587
50075	KFH - OAKLAND	7131.2	0.039	0.361	0.400	$ 19,643
50076	KFH - SAN FRANCISCO	7132.4	0.039	0.361	0.400	$ 19,643
50077	MERCY HOSPITAL	6346.8	0.034	0.300	0.334	$ 16,377
50078	SAN PEDRO PENINSULA	5498.4	0.028	0.268	0.296	$ 16,630
50079	DOCTORS MEDICAL CENTER-SAN PABLO	7288.6	0.021	0.289	0.310	$ 19,641
50082	ST. JOHN'S REGIONAL MEDICAL CENTER	5247.3	0.074	0.343	0.417	$ 14,990
50084	ST. JOSEPH'S MEDICAL CENTER	5020.2	0.022	0.260	0.282	$ 15,146
50088	SAN LUIS OBISPO GENERAL HOSPITAL	4755.3	0.025	0.735	0.760	$ 15,193
50089	COMMUNITY HOSPITAL OF SAN BERNARDINO	7291.2	0.046	0.315	0.361	$ 15,701
50090	SONOMA VALLEY HEALTH CARE DIST.	5159.2	0.055	0.437	0.492	$ 17,206
50091	COMMUNITY HOSPITALS OF HUNTINGTON PK	9079.1	0.032	0.277	0.309	$ 16,633
50092	GLENN MEDICAL CENTER	4730.9	0.050	0.747	0.797	$ 14,357
50093	SAINT AGNES MEDICAL CENTER	4603.7	0.043	0.353	0.396	$ 14,607
50096	DR'S HOSPITAL OF WEST COVINA	5406.7	0.039	0.304	0.343	$ 16,636
50097	GENERAL HOSPITAL	4303.8	0.033	0.367	0.400	$ 14,357
50099	SAN ANTONIO COMMUNITY HOSPITAL	5661.2	0.031	0.293	0.324	$ 15,688
50100	SHARP MEMORIAL HOSPITAL	5783.9	0.041	0.359	0.400	$ 16,377
50101	SUTTER SOLANO MEDICAL CENTER	6430.3	0.025	0.290	0.315	$ 16,823
50102	PARKVIEW COMMUNITY HOSPITAL	5928.8	0.024	0.340	0.364	$ 15,676
50103	WHITE MEMORIAL MEDICAL CENTER	8308.7	0.044	0.335	0.379	$ 16,637
50104	ST. FRANCIS MEDICAL CENTER	7922.8	0.022	0.271	0.293	$ 16,623
50107	MARIAN MEDICAL CENTER	5215.2	0.058	0.378	0.436	$ 15,112
50108	SUTTER COMMUNITY HOSPITAL	5789.3	0.036	0.278	0.314	$ 16,559
50110	LOMPOC DISTRICT HOSPITAL	4530.4	0.042	0.436	0.478	$ 15,113
50111	TEMPLE COMMUNITY HOSPITAL	7509.1	0.016	0.285	0.301	$ 16,615
50112	SANTA MONICA HOSPITAL	5570.3	0.039	0.355	0.394	$ 16,631
50113	SAN MATEO COUNTY GENERAL HOSPITAL	6178.8	0.028	0.886	0.914	$ 18,828
50114	SHERMAN OAKS HOSP AND HLTH CENTER	5268.7	0.047	0.430	0.477	$ 16,631
50115	PALOMAR MEDICAL CENTER	5573.1	0.044	0.342	0.386	$ 16,382
50116	NORTHRIDGE HOSPITAL MEDICAL CENTER	5974.7	0.029	0.275	0.304	$ 16,630
50117	MERCY HOSPITAL & HEALTH SYSTEM	4954.2	0.021	0.308	0.329	$ 14,357
50118	DOCTORS HOSPITAL OF MANTECA	4540.3	0.029	0.225	0.254	$ 15,145

50121	HANFORD COMMUNITY MEDICAL CENTER	4303.8	0.021	0.391	0.412	$ 14,357
50122	DAMERON HOSPITAL	5554.0	0.015	0.280	0.295	$ 15,147
50124	VERDUGO HILLS HOSPITAL	5057.3	0.053	0.310	0.363	$ 16,648
50125	ALEXIAN BROS. HOSPITAL	7865.2	0.032	0.280	0.312	$ 18,198
50126	VALLEY PRESBYTERIAN HOSPITAL	6606.0	0.047	0.312	0.359	$ 16,643
50127	WOODLAND MEMORIAL HOSPITAL	4896.1	0.046	0.476	0.522	$ 14,704
50128	TRI-CITY MEDICAL CENTER	5188.6	0.043	0.309	0.352	$ 16,385
50129	ST. BERNARDINE MEDICAL CENTER	6071.7	0.072	0.392	0.464	$ 15,713
50131	NOVATO COMMUNITY HOSPITAL	5729.5	0.026	0.464	0.490	$ 18,831
50132	SAN GABRIEL VALLEY MEDICAL CENTER	5928.3	0.038	0.251	0.289	$ 16,643
50133	RIDEOUT MEMORIAL HOSPITAL	5334.9	0.044	0.443	0.487	$ 15,225
50135	HOLLYWOOD COMM. HOSP OF HOLLYWOOD	6497.7	0.027	0.377	0.404	$ 16,620
50136	PETALUMA VALLEY HOSPITAL	5159.2	0.036	0.489	0.525	$ 17,214
50137	KAISER FOUNDATION HOSPITALS-PANORAMA	5088.3	0.039	0.361	0.400	$ 16,631
50138	KAISER FOUNDATION HOSPITALS - SUNSET	5938.5	0.039	0.361	0.400	$ 16,631
50139	KAISER FOUND. HOSPITALS - BELLFLOWER	5118.5	0.039	0.361	0.400	$ 16,631
50140	KAISER FOUND. HOSPITALS - FONTANA	5082.3	0.039	0.361	0.400	$ 15,689
50144	BROTMAN MEDICAL CENTER	6207.8	0.050	0.318	0.368	$ 16,644
50145	COMMUNITY HOSP. MONTEREY PENINSULA	5869.7	0.032	0.463	0.495	$ 19,113
50148	PLUMAS DISTRICT HOSPITAL MCARE RPT	4346.0	0.034	0.466	0.500	$ 14,357
50149	CALIFORNIA HOSPITAL MEDICAL CENTER	8562.6	0.035	0.353	0.388	$ 16,628
50150	SIERRA NEVADA MEMORIAL HOSPITAL	4948.0	0.073	0.459	0.532	$ 16,500
50152	SAINT FRANCIS MEMORIAL HOSPITAL	7135.7	0.032	0.292	0.324	$ 18,839
50153	O'CONNOR HOSPITAL	5991.8	0.036	0.363	0.399	$ 18,195
50155	MONROVIA COMMUNITY HOSPITAL	5408.9	0.039	0.314	0.353	$ 16,635
50158	ENCINO-TARZANA REG MED CENTER	5071.9	0.038	0.361	0.399	$ 16,630
50159	VENTURA COUNTY MEDICAL CENTER	7638.6	0.024	0.504	0.528	$ 14,993
50167	SAN JOAQUIN GENERAL HOSPITAL	7581.0	0.048	0.451	0.499	$ 15,146
50168	ST. JUDE MEDICAL CENTER	4875.0	0.022	0.282	0.304	$ 15,983
50169	PRESBYTERIAN INTERCOMMUNITY	5662.7	0.041	0.290	0.331	$ 16,640
50170	LONG BEACH COMMUNITY MEDICAL CENTER	5651.6	0.032	0.333	0.365	$ 16,627
50172	REDWOOD MEMORIAL HOSPITAL	4303.8	0.036	0.428	0.464	$ 14,357
50173	ANAHEIM GENERAL HOSPITAL	6486.4	0.013	0.275	0.288	$ 15,972
50174	SANTA ROSA MEMORIAL HOSPITAL	5179.2	0.039	0.462	0.501	$ 17,212
50175	WHITTIER HOSPITAL MEDICAL CENTER	6697.3	0.039	0.291	0.330	$ 16,638
50177	SANTA PAULA MEMORIAL HOSPITAL	4693.0	0.028	0.546	0.574	$ 14,993
50179	EMANUEL MEDICAL CENTER	5133.3	0.038	0.353	0.391	$ 14,907
50180	JOHN MUIR MEDICAL CENTER	5985.2	0.036	0.305	0.341	$ 19,644
50186	SCRIPPS HOSPITAL - EAST COUNTY	5747.0	0.051	0.370	0.421	$ 16,384
50188	COMM HOSP.& REHAB- LOS GATOS	5534.0	0.045	0.253	0.298	$ 18,209
50189	GEORGE L. MEE MEMORIAL HOSPITAL	6039.3	0.036	0.493	0.529	$ 19,112
50191	ST MARY MEDICAL CENTER	7071.6	0.039	0.255	0.294	$ 16,643
50192	SIERRA KINGS DISTRICT HOSPITAL	4572.4	0.038	0.520	0.558	$ 14,607
50193	SOUTH COAST MEDICAL CENTER	4867.8	0.027	0.268	0.295	$ 15,991
50194	WATSONVILLE COMMUNITY HOSPITAL	6816.0	0.030	0.387	0.417	$ 18,694
50195	WASHINGTON HOSPITAL DISTRICT	6805.6	0.024	0.336	0.360	$ 19,641
50196	CENTRAL VALLEY GENERAL HOSP	4456.1	0.021	0.382	0.403	$ 14,357
50197	SEQUOIA HEALTH SERVICES	5739.1	0.030	0.449	0.479	$ 18,833
50204	LANCASTER HOSPITAL	5201.4	0.022	0.251	0.273	$ 16,625
50205	HUNTINGTON EAST VALLEY HOSPITAL	7228.2	0.044	0.419	0.463	$ 16,630

50207	FREMONT MEDICAL CENTER	5423.3	0.030	0.494	0.524	$ 15,226
50211	ALAMEDA HOSPITAL	6385.2	0.014	0.250	0.264	$ 19,641
50213	UNIVERSITY MEDICAL CENTER	7604.5	0.021	0.439	0.460	$ 14,607
50214	GRANADA HILLS COMMUNITY HOSPITAL	6473.8	0.022	0.303	0.325	$ 16,620
50215	SAN JOSE MEDICAL CENTER	7139.9	0.130	0.425	0.555	$ 18,227
50217	FAIRCHILD MEDICAL CENTER	4346.0	0.045	0.616	0.661	$ 14,357
50219	COAST PLAZA DOCTORS HOSPITAL	6698.9	0.023	0.288	0.311	$ 16,622
50222	SHARP CHULA VISTA MEDICAL CTR	6376.7	0.044	0.326	0.370	$ 16,384
50224	HOAG MEMORIAL HOSPITAL PRESBYTERIAN	4869.0	0.036	0.380	0.416	$ 15,989
50225	FEATHER RIVER HOSPITAL	4510.5	0.047	0.450	0.497	$ 14,416
50226	ANAHEIM MEMORIAL MEDICAL CENTER	5034.2	0.052	0.299	0.351	$ 16,013
50228	SAN FRANCISCO GENERAL HOSPITAL	10776.1	0.016	0.535	0.551	$ 18,827
50230	GARDEN GROVE MEDICAL CENTER	6972.4	0.029	0.262	0.291	$ 15,994
50231	POMONA VALLEY HOSPITAL MED CTR	6615.4	0.024	0.264	0.288	$ 16,626
50232	FRENCH HOSPITAL MEDICAL CENTER	4562.2	0.033	0.262	0.295	$ 15,190
50234	SHARP CORONADO HOSPITAL	4979.7	0.035	0.464	0.499	$ 16,365
50235	PROVIDENCE SAINT JOSEPH MED CTR	5361.5	0.046	0.403	0.449	$ 16,632
50236	SIMI VALLEY HOSPITAL	5177.0	0.036	0.326	0.362	$ 16,582
50238	METHODIST HOSPITAL OF SOUTHERN CA	5065.0	0.042	0.353	0.395	$ 16,634
50239	GLENDALE ADVENTIST MEDICAL CENTER	7355.8	0.052	0.607	0.659	$ 16,624
50240	CENTINELA HOSPITAL MEDICAL CENTER	6795.9	0.049	0.298	0.347	$ 16,646
50242	DOMINICAN SANTA CRUZ HOSPITAL	6176.1	0.034	0.331	0.365	$ 18,686
50243	DESERT HOSPITAL	5437.4	0.044	0.260	0.304	$ 15,708
50245	ARROWHEAD REGIONAL MEDICAL CENTER	8153.0	0.015	0.476	0.491	$ 15,662
50248	NATIVIDAD MEDICAL CENTER	8830.3	0.016	0.393	0.409	$ 19,124
50251	LASSEN COMMUNITY HOSPITAL	4730.9	0.039	0.476	0.515	$ 14,357
50253	LINCOLN LLC	6066.4	0.028	0.301	0.329	$ 15,988
50254	MARSHALL HOSPITAL	5033.6	0.085	0.431	0.516	$ 16,577
50256	ORTHOPAEDIC HOSPITAL	6853.0	0.046	0.447	0.493	$ 16,629
50257	GOOD SAMARITAN HOSPITAL	4494.2	0.080	0.320	0.400	$ 14,358
50260	MOUNTAINS COMMUNITY HOSPITAL	4770.8	0.042	0.460	0.502	$ 15,684
50261	SIERRA VIEW DISTRICT HOSPITAL	5092.2	0.064	0.390	0.454	$ 14,357
50262	UCLA MEDICAL CENTER	7975.2	0.039	0.387	0.426	$ 16,629
50264	SAN LEANDRO HOSPITAL	5974.6	0.039	0.337	0.376	$ 19,644
50267	DANIEL FREEMAN MEMORIAL HOSP	6571.3	0.023	0.248	0.271	$ 16,626
50270	SMH - CHULA VISTA	6795.5	0.036	0.305	0.341	$ 16,379
50272	REDLANDS COMMUNITY HOSPITAL	4783.7	0.035	0.292	0.327	$ 15,693
50276	CONTRA COSTA REGIONAL MEDICAL CNTR	9454.0	0.017	0.666	0.683	$ 19,639
50277	PACIFIC HOSPITAL OF LONG BEACH	7263.8	0.024	0.387	0.411	$ 16,617
50278	PROVIDENCE HOLY CROSS MEDICAL CENTER	5769.4	0.039	0.282	0.321	$ 16,639
50279	HI - DESERT MEDICAL CENTER	4817.5	0.054	0.491	0.545	$ 15,690
50280	MERCY MEDICAL CENTER	5635.0	0.029	0.296	0.325	$ 16,206
50281	ALHAMBRA HOSPITAL	7401.6	0.039	0.320	0.359	$ 16,635
50282	MARTIN LUTHER HOSPITAL	5945.2	0.038	0.321	0.359	$ 15,996
50283	VALLEY MEMORIAL HOSPITAL	5974.6	0.035	0.269	0.304	$ 19,644
50289	SETON MEDICAL CENTER	6749.3	0.036	0.357	0.393	$ 18,837
50290	SAINT JOHN'S HOSPITAL	5063.8	0.027	0.307	0.334	$ 16,625
50291	SUTTER COMMUNITY HOSPITAL SANTA ROSA	8312.9	0.039	0.499	0.538	$ 17,213
50292	RIVERSIDE COUNTY REGIONAL MED CENTER	7310.5	0.018	0.480	0.498	$ 15,664
50293	PACIFIC COAST HOSPITAL	7084.4	0.112	0.835	0.947	$ 18,842
50295	MERCY HOSPITAL	4464.2	0.055	0.314	0.369	$ 14,358

50296	HAZEL HAWKINS MEM. HOSPITAL	5541.7	0.036	0.442	0.478	$ 18,491
50298	BARSTOW COMMUNITY HOSPITAL	4770.8	0.036	0.282	0.318	$ 15,696
50299	NHMC-SHERMAN WAY CAMPUS	7150.0	0.042	0.351	0.393	$ 16,634
50300	ST. MARY REGIONAL	5606.9	0.040	0.325	0.365	$ 15,694
50301	UKIAH VALLEY MEDICAL CENTER	5263.3	0.034	0.486	0.520	$ 16,961
50305	ALTA BATES MEDICAL CENTER	7233.9	0.028	0.278	0.306	$ 19,643
50308	EL CAMINO HOSPITAL	5542.8	0.031	0.335	0.366	$ 18,194
50309	SUTTER ROSEVILLE MEDICAL CENTER	5237.1	0.035	0.287	0.322	$ 16,557
50312	REDDING MEDICAL CENTER	5071.6	0.015	0.361	0.376	$ 16,211
50313	SUTTER TRACY COMMUNITY HOSPITAL	4540.3	0.058	0.301	0.359	$ 15,144
50315	KERN MEDICAL CENTER	7908.4	0.030	0.574	0.604	$ 14,357
50320	ALAMEDA COUNTY MEDICAL CENTER	10196.1	0.017	0.608	0.625	$ 19,639
50324	SCRIPPS MEMORIAL HOSPITAL - LA JOLLA	4990.5	0.034	0.280	0.314	$ 16,380
50325	TUOLUMNE GENERAL HOSPITAL	4303.8	0.022	0.419	0.441	$ 14,357
50327	LOMA LINDA UNIVERSITY MEDICAL CTR.	7076.6	0.036	0.289	0.325	$ 15,695
50329	CORONA REGIONAL MEDICAL CENTER	5574.6	0.028	0.274	0.302	$ 15,687
50331	HEALDSBURG GENERAL HOSPITAL	5159.2	0.024	0.459	0.483	$ 17,218
50333	SENECA DISTRICT HOSPITAL	4346.0	0.021	0.532	0.553	$ 14,357
50334	SALINAS VALLEY MEMORIAL HOSPITAL	6197.3	0.023	0.442	0.465	$ 19,120
50335	SONORA COMMUNITY HOSPITAL	4303.8	0.039	0.460	0.499	$ 14,357
50336	LODI MEMORIAL HOSPITAL	4748.4	0.030	0.312	0.342	$ 15,146
50337	DESERT PALMS COMMUNITY HOSPITAL	5057.3	0.042	0.394	0.436	$ 16,630
50342	PIONEERS MEM. HOSPITAL	4456.1	0.033	0.426	0.459	$ 14,357
50345	HOSPITAL NAME NOT AVAILABLE	4781.9	0.051	0.497	0.548	$ 15,687
50348	UCI MEDICAL CENTER	8187.6	0.027	0.322	0.349	$ 15,985
50349	CORCORAN DISTRICT HOSPITAL	4456.1	0.030	0.429	0.459	$ 14,357
50350	BEVERLY COMMUNITY HOSPITAL	6431.8	0.023	0.305	0.328	$ 16,621
50351	TORRANCE MEMORIAL MEDICAL CENTER	5063.4	0.031	0.323	0.354	$ 16,627
50352	BARTON MEMORIAL HOSPITAL	5083.0	0.070	0.516	0.586	$ 16,561
50353	LITTLE COMPANY OF MARY HOSPITAL	5067.1	0.033	0.295	0.328	$ 16,632
50355	SIERRA VALLEY DISTRICT HOSPITAL	4346.0	0.111	0.640	0.751	$ 14,358
50357	GOLETA VALLEY COTTAGE HOSPITAL	4540.5	0.036	0.351	0.387	$ 15,113
50359	TULARE DISTRICT HOSPITAL	5249.7	0.041	0.430	0.471	$ 14,357
50360	MARIN GENERAL HOSPITAL	5875.4	0.050	0.425	0.475	$ 18,840
50366	MARK TWAIN ST. JOSEPH'S HOSPITAL	4346.0	0.022	0.346	0.368	$ 14,357
50367	NORTHBAY MEDICAL CENTER	6561.2	0.034	0.233	0.267	$ 16,816
50369	QUEEN OF THE VALLEY HOSPITAL	6821.2	0.023	0.356	0.379	$ 16,618
50373	LAC+USC MEDICAL CENTER	9863.6	0.016	0.347	0.363	$ 16,612
50376	HARBOR-UCLA MEDICAL CENTER	10439.6	0.039	0.296	0.335	$ 16,637
50377	CHOWCHILLA DISTRICT MEMORIAL HOSP	4378.7	0.032	0.642	0.674	$ 14,607
50378	PACIFICA OF THE VALLEY	8053.4	0.059	0.476	0.535	$ 16,635
50379	WEST SIDE DISTRICT HOSPITAL	4346.0	0.127	0.832	0.959	$ 14,357
50380	GOOD SAMARITAN HOSPITAL	5539.0	0.106	0.556	0.662	$ 18,211
50382	INTER-COMMUNITY MEDICAL CENTER	6123.9	0.026	0.340	0.366	$ 16,621
50385	PALM DRIVE HOSPITAL	5159.2	0.030	0.494	0.524	$ 17,216
50388	SOUTHERN INYO HOSPITAL	4346.0	0.055	0.753	0.808	$ 14,357
50390	HEMET VALLEY MEDICAL CENTER	5342.1	0.029	0.308	0.337	$ 15,685
50391	SANTA TERESITA HOSPITAL	5281.0	0.026	0.410	0.436	$ 16,617
50392	TRINITY HOSPITAL	4730.9	0.015	0.610	0.625	$ 14,357
50393	DOWNEY COMMUNITY HOSPITAL	5960.7	0.087	0.716	0.803	$ 16,635
50394	COMM MEM HOSP OF SAN BUENAVENTURA	4498.9	0.026	0.406	0.432	$ 14,993

50396	SANTA BARBARA COTTAGE HOSPITAL	5094.9	0.022	0.245	0.267	$ 15,113
50397	COALINGA REGIONAL MEDICAL CENTER	4421.6	0.085	0.483	0.568	$ 14,607
50401	WASHINGTON MEDICAL CENTER	5057.3	0.042	0.290	0.332	$ 16,641
50404	BIGGS-GRIDLEY MEMORIAL HOSP.-CARE	4321.4	0.015	0.424	0.439	$ 14,416
50406	MAYERS MEMORIAL HOSPITAL MCARE RPT	4905.9	0.040	0.524	0.564	$ 16,208
50407	CHINESE HOSPITAL	5983.1	0.034	0.513	0.547	$ 18,833
50410	SANGER GENERAL HOSPITAL	4572.4	0.032	0.443	0.475	$ 14,607
50411	KAISER FOUNDATION HOSPITALS -HARBOR	5104.8	0.039	0.361	0.400	$ 16,631
50414	MERCY HOSPITAL OF FOLSOM	5033.6	0.072	0.326	0.398	$ 16,583
50417	SUTTER COAST HOSPITAL	4346.0	0.068	0.439	0.507	$ 14,357
50419	MERCY MEDICAL CENTER MT. SHASTA	4905.9	0.053	0.517	0.570	$ 16,206
50420	ROBERT F. KENNEDY MEDICAL CENTER	7318.8	0.036	0.392	0.428	$ 16,626
50423	PALO VERDE HOSPITAL	5030.7	0.053	0.390	0.443	$ 15,698
50424	GREEN HOSPITAL OF SCRIPPS CLINIC	5539.0	0.042	0.408	0.450	$ 16,374
50425	KFH - SACRAMENTO	5398.6	0.039	0.361	0.400	$ 16,553
50426	WEST ANAHEIM MEDICAL CENTER	5079.2	0.024	0.242	0.266	$ 15,990
50427	AVALON MUNICIPAL HOSPITAL	5106.9	0.039	0.610	0.649	$ 16,617
50430	MODOC MEDICAL CENTER	4730.9	0.019	0.557	0.576	$ 14,357
50432	GARFIELD MEDICAL CTR.	8463.2	0.016	0.361	0.377	$ 16,611
50433	INDIAN VALLEY HOSPITAL	4346.0	0.020	0.563	0.583	$ 14,357
50434	COLUSA COMMUNITY HOSPITAL	4730.9	0.039	0.596	0.635	$ 14,357
50435	FALLBROOK DISTRICT HOSPITAL	5028.5	0.024	0.374	0.398	$ 16,362
50438	HUNTINGTON MEMORIAL HOSPITAL	6155.8	0.028	0.332	0.360	$ 16,624
50440	HOWARD MEMORIAL HOSPITAL	4303.8	0.049	0.433	0.482	$ 14,357
50441	STANFORD UNIVERSITY HOSPITAL	8212.0	0.032	0.327	0.359	$ 18,195
50443	JOHN C. FREMONT HOSPITAL	4346.0	0.027	0.518	0.545	$ 14,357
50444	SUTTER MERCED MEDICAL CENTER	6086.4	0.033	0.340	0.373	$ 14,357
50446	TEHACHAPI VALLEY HOSP. DIST.	4346.0	0.051	0.974	1.025	$ 14,357
50447	VILLA VIEW COMMUNITY HOSPITAL	7531.8	0.068	0.374	0.442	$ 16,397
50448	RIDGECREST REGIONAL HOSPITAL	4346.0	0.045	0.442	0.487	$ 14,357
50449	VALLEY COMMUNITY HOSPITAL	4530.4	0.059	0.240	0.299	$ 15,110
50454	UC SAN FRANCISCO MEDICAL CENTER	9962.8	0.033	0.324	0.357	$ 18,838
50455	SAN JOAQUIN COMMUNITY HOSPITAL	5021.5	0.022	0.352	0.374	$ 14,357
50456	GARDENA PHYSICIANS HOSP. INC.	5057.3	0.048	0.694	0.742	$ 16,619
50457	ST. MARY MEDICAL CENTER	6681.9	0.033	0.272	0.305	$ 18,840
50464	DOCTORS MEDICAL CENTER OF MODESTO	5775.5	0.018	0.361	0.379	$ 14,907
50468	MEMORIAL HOSPITAL OF GARDENA	6576.1	0.022	0.310	0.332	$ 16,620
50469	COLORADO RIVER MEDICAL CENTER	4817.5	0.022	0.777	0.799	$ 15,661
50470	SELMA DISTRICT HOSPITAL	4618.3	0.022	0.615	0.637	$ 14,607
50471	GOOD SAMARITAN HOSPITAL	6314.2	0.016	0.293	0.309	$ 16,614
50476	SUTTER LAKESIDE HOSPITAL	4346.0	0.040	0.418	0.458	$ 14,357
50477	MIDWAY HOSPITAL MEDICAL CENTER	5687.7	0.052	0.234	0.286	$ 16,661
50478	SANTA YNEZ VALLEY COTTAGE HOSPITAL	4574.9	0.053	0.424	0.477	$ 15,112
50481	WEST HILLS REG MEDICAL CENTER	5065.2	0.025	0.249	0.274	$ 16,628
50482	JEROLD PHELPS COMMUNITY HOSPITAL	4730.9	0.029	0.661	0.690	$ 14,357
50485	LONG BEACH MEMORIAL MEDICAL CENTER	6475.2	0.038	0.401	0.439	$ 16,627
50488	EDEN MEDICAL CENTER	6177.8	0.026	0.327	0.353	$ 19,642
50491	SANTA ANA HOSPITAL MEDICAL CENTER	5078.2	0.129	0.371	0.500	$ 16,056
50492	CLOVIS COMMUNITY HOSPITAL	4663.9	0.087	0.400	0.487	$ 14,606
50494	TAHOE FOREST HOSPITAL	4996.6	0.050	0.539	0.589	$ 16,507

50496	MT. DIABLO MEDICAL CENTER	6186.0	0.032	0.265	0.297	$ 19,644
50497	DOS PALOS MEMORIAL HOSPITAL	4303.8	0.039	0.365	0.404	$ 14,357
50498	SUTTER AUBURN FAITH HOSPITAL	5033.6	0.026	0.320	0.346	$ 16,545
50502	ST. VINCENT MEDICAL CENTER	6665.5	0.031	0.297	0.328	$ 16,630
50503	SCRIPPS MEMORIAL HOSPITAL-ENCINITAS	4979.7	0.031	0.302	0.333	$ 16,374
50506	SIERRA VISTA REGIONAL MED CTR	4935.5	0.027	0.253	0.280	$ 15,191
50510	KFH - SAN RAFAEL	5977.4	0.039	0.361	0.400	$ 19,643
50512	KFH - HAYWARD	6050.0	0.039	0.361	0.400	$ 19,643
50515	KAISER FOUND. HOSPITALS -SAN DIEGO	5093.3	0.039	0.361	0.400	$ 16,376
50516	MERCY SAN JUAN HOSPITAL	5633.1	0.025	0.243	0.268	$ 16,551
50517	VICTOR VALLEY COMMUNITY HOSPITAL	5987.7	0.030	0.281	0.311	$ 15,689
50522	DOCTORS HOSPITAL OF PINOLE	5974.6	0.023	0.261	0.284	$ 19,642
50523	SUTTER DELTA MEDICAL CENTER	7027.7	0.029	0.303	0.332	$ 19,643
50526	HUNTINGTON BEACH MEDICAL CENTER	5932.9	0.033	0.248	0.281	$ 16,001
50528	MEMORIAL HOSPITAL-LOS BANOS	4538.5	0.031	0.292	0.323	$ 14,357
50531	BELLFLOWER MEDICAL CENTER	7475.7	0.015	0.258	0.273	$ 16,616
50534	JOHN F. KENNEDY MEMORIAL HOSP.	6752.0	0.025	0.212	0.237	$ 15,692
50535	COASTAL COMMUNITIES HOSPITAL	7877.0	0.038	0.320	0.358	$ 15,996
50537	SUTTER DAVIS HOSPITAL	4407.9	0.080	0.284	0.364	$ 14,703
50539	REDBUD COMMUNITY HOSPITAL	4346.0	0.036	0.359	0.395	$ 14,357
50541	KFH - REDWOOD CITY	5976.1	0.039	0.361	0.400	$ 19,643
50542	KERN VALLEY HOSPITAL DISTRICT	4346.0	0.083	0.447	0.530	$ 14,358
50543	COLLEGE HOSPITAL COSTA MESA	7210.1	0.026	0.260	0.286	$ 15,990
50545	LANTERMAN DEVELOPMENTAL CENTER	5281.0	0.039	0.687	0.726	$ 16,615
50546	PORTERVILLE DEVELOPMENTAL CENTER	4303.8	0.014	0.365	0.379	$ 14,357
50547	SONOMA DEVELOPMENTAL CENTER	5387.6	0.039	0.782	0.821	$ 17,218
50549	LOS ROBLES MEDICAL CENTER	4977.9	0.029	0.389	0.418	$ 16,586
50550	CHAPMAN MEDICAL CENTER	5626.9	0.040	0.315	0.355	$ 15,999
50551	LOS ALAMITOS MEDICAL CTR.	4875.4	0.027	0.255	0.282	$ 15,992
50552	MOTION PICTURE AND TELEVISION FUND	5057.3	0.082	0.946	1.028	$ 16,624
50557	MEMORIAL HOSPITAL MODESTO	5018.9	0.017	0.211	0.228	$ 14,907
50559	DANIEL FREEMAN MARINA HOSPITAL	5069.8	0.035	0.291	0.326	$ 16,634
50561	KAISER FOUND. HOSPITAL - WEST LA	5088.7	0.039	0.361	0.400	$ 16,631
50564	PACIFICA HOSPITAL	4863.3	0.064	0.446	0.510	$ 16,004
50566	EASTERN PLUMAS DISTRICT HOSP	4346.0	0.032	0.387	0.419	$ 14,357
50567	MISSION HOSP REGIONAL MEDICAL CTR	4873.4	0.035	0.274	0.309	$ 15,999
50568	MADERA COMMUNITY HOSPITAL	5863.2	0.020	0.470	0.490	$ 14,607
50569	MENDOCINO COAST DISTRICT HOSPITAL	5133.1	0.053	0.598	0.651	$ 16,958
50570	FOUNTAIN VALLEY REG MEDICAL CENTER	6380.7	0.013	0.273	0.286	$ 15,973
50571	SUBURBAN MEDICAL CENTER	8142.0	0.038	0.230	0.268	$ 16,647
50573	EISENHOWER MEMORIAL HOSPITAL	4779.7	0.064	0.328	0.392	$ 15,716
50575	TRI-CITY REGIONAL MEDICAL CENTER	6475.1	0.039	0.365	0.404	$ 16,630
50577	SANTA MARTA HOSPITAL	7722.8	0.023	0.458	0.481	$ 16,613
50578	MARTIN LUTHER KING, JR./DREW MEDICAL	10471.7	0.019	0.338	0.357	$ 16,615
50579	CENTURY CITY HOSP	5317.2	0.055	0.235	0.290	$ 16,664
50580	LAPALMA INTERCOMMUNITY HOSPITAL	5889.6	0.033	0.257	0.290	$ 15,999
50581	LAKEWOOD REGIONAL MED. CTR.	5585.0	0.031	0.250	0.281	$ 16,635
50583	ALVARADO COMMUNITY HOSPITAL	5628.4	0.035	0.245	0.280	$ 16,386
50584	US FAMILYCARE MEDICAL CENTER	5954.8	0.043	0.239	0.282	$ 15,712
50585	SAN CLEMENTE HOSPITAL	4863.3	0.094	0.510	0.604	$ 16,016
50586	CHINO VALLEY MEDICAL CENTER	5966.5	0.035	0.329	0.364	$ 15,689
50588	SAN DIMAS COMMUNITY HOSPITAL	5057.3	0.028	0.235	0.263	$ 16,634
50589	PLACENTIA LINDA COMMUNITY HOSPITAL	4872.5	0.041	0.311	0.352	$ 16,000

50590	METHODIST HOSPITAL OF SACRAMENTO	6464.5	0.028	0.356	0.384	$ 16,544
50591	MONTEREY PARK HOSPITAL	7802.9	0.036	0.222	0.258	$ 16,646
50592	BREA COMMUNITY HOSPITAL	4876.0	0.029	0.285	0.314	$ 15,991
50594	WESTERN MEDICAL CENTER ANAHEIM	6282.6	0.062	0.302	0.364	$ 16,022
50597	FOOTHILL PRESBYTERIAN HOSPITAL	5389.1	0.031	0.398	0.429	$ 16,622
50598	MISSION BAY MEMORIAL HOSPITAL	4979.7	0.027	0.352	0.379	$ 16,366
50599	UC DAVIS MEDICAL CENTER	9301.9	0.039	0.361	0.400	$ 16,553
50601	TARZANA ENCINO REGIONAL MED CTR	5670.2	0.028	0.361	0.389	$ 16,622
50603	SADDLEBACK MEMORIAL MEDICAL CENTER	4871.2	0.026	0.387	0.413	$ 15,979
50604	KFH - SANTA TERESA	5536.5	0.039	0.361	0.400	$ 18,196
50608	DELANO REGIONAL MEDICAL CNT.	6006.5	0.029	0.266	0.295	$ 14,357
50609	KAISER FOUNDATION HOSPITALS -ANAHEIM	5468.5	0.039	0.361	0.400	$ 16,631
50613	SETON COASTSIDE HOSPITAL	5729.5	0.039	0.365	0.404	$ 18,838
50615	GREATER EL MONTE COMMUNITY HOSPITAL	8024.6	0.048	0.244	0.292	$ 16,655
50616	ST. JOHN'S PLEASANT VALLEY HOSPITAL	4494.1	0.027	0.347	0.374	$ 14,992
50618	BEAR VALLEY COMMUNITY HOSPITAL	4817.5	0.042	0.645	0.687	$ 15,674
50623	HIGH DESERT HOSPITAL	5281.0	0.027	0.486	0.513	$ 16,615
50624	HENRY MAYO NEWHALL MEMORIAL HOSPITAL	5067.0	0.051	0.302	0.353	$ 16,647
50625	CEDARS-SINAI MEDICAL CENTER	6622.9	0.025	0.275	0.300	$ 16,626
50630	INLAND VALLEY REGIONAL MEDICAL CENTER	4770.8	0.047	0.358	0.405	$ 15,697
50633	TWIN CITIES COMMUNITY HOSPITAL	4553.8	0.024	0.235	0.259	$ 15,191
50636	POMERADO HOSPITAL	4979.7	0.043	0.347	0.390	$ 16,380
50638	SOUTHERN MONO HEALTH CARE DISTRICT	4346.0	0.098	0.863	0.961	$ 14,357
50641	EAST LA DOCTOR'S HOSPITAL	7814.3	0.041	0.389	0.430	$ 16,630
50643	HOSPITAL NAME NOT AVAILABLE	5710.0	0.036	0.606	0.642	$ 3,953
50644	LOS ANGELES METROPOLITAN MED CNTR	8106.8	0.039	0.234	0.273	$ 16,647
50662	AGNEWS DEVELOPMENTAL CENTER	5778.9	0.039	0.906	0.945	$ 18,184
50663	LOS ANGELES COMMUNITY HOSPITAL	8162.8	0.018	0.327	0.345	$ 16,615
50667	NELSON M. HOLDERMAN	5042.8	0.024	1.182	1.206	$ 16,833
50668	LAGUNA HONDA HOSPITAL	5729.5	0.022	0.998	1.020	$ 18,826
50670	NORTH COAST HEALTH CARE CENTERS	5159.2	0.058	0.371	0.429	$ 17,201
50674	KFH - SOUTH SACRAMENTO	5474.7	0.039	0.361	0.400	$ 16,553
50676	SURPRISE VALLEY COMM HOSPITAL	4346.0	0.062	0.804	0.866	$ 14,357
50677	KAISER FOUND. HOSP. - WOODLAND HILLS	5392.0	0.039	0.361	0.400	$ 16,631
50678	ORANGE COAST MEMORIAL MEDICAL CENTER	4867.4	0.033	0.452	0.485	$ 15,981
50680	VACAVALLEY HOSPITAL	5042.8	0.034	0.218	0.252	$ 16,815
50682	KINGSBURG MEDICAL CENTER	4572.4	0.086	0.361	0.447	$ 14,606
50684	MENIFEE VALLEY MEDICAL CENTER	4770.8	0.048	0.265	0.313	$ 15,712
50685	SOUTH VALLEY HOSPITAL	5534.0	0.027	0.427	0.454	$ 18,188
50686	KAISER FOUND. HOSPITALS - RIVERSIDE	5140.1	0.039	0.361	0.400	$ 15,993
50688	SAINT LOUISE HOSPITAL	5534.0	0.089	0.417	0.506	$ 18,214
50689	SAN RAMON REG. MEDICAL CENTER	5981.9	0.087	0.308	0.395	$ 19,651
50690	KFH - SANTA ROSA	5161.2	0.039	0.361	0.400	$ 17,208
50693	IRVINE MEDICAL CENTER	5021.5	0.129	0.300	0.429	$ 16,073
50694	MORENO VALLEY COMMUNITY HOSPITAL	4981.7	0.063	0.278	0.341	$ 15,725
50695	ST. DOMINIC'S HOSPITAL	4540.3	0.072	0.380	0.452	$ 15,144
50696	USC UNIVERSITY HOSPITAL	6232.7	0.071	0.278	0.349	$ 16,669
50697	PATIENT'S HOSPITAL OF REDDING	4858.2	0.076	0.486	0.562	$ 16,202
50699	REDDING SPECIALTY HOSPITAL	4858.2	0.060	0.533	0.593	$ 16,205
50701	SHARP HEALTHCARE MURRIETA	4979.7	0.045	0.370	0.415	$ 16,380

50704	MISSION COMMUNITY HOSPITAL	7949.1	0.030	0.369	0.399	$ 16,623
50707	RECOVERY INN OF MENLO PARK	5729.5	0.113	0.749	0.862	$ 18,844
50708	FRESNO SURGERY CENTER	4378.7	0.100	0.498	0.598	$ 14,607
50709	DESERT VALLEY HOSPITAL	4770.8	0.057	0.312	0.369	$ 15,712
50710	KFH - FRESNO	4379.7	0.036	0.361	0.397	$ 14,607
50713	LINCOLN HOSPITAL MEDICAL CENTER	5281.0	0.036	0.491	0.527	$ 16,621
50714	SUTTER MATERNITY & SURGERY CENTER	5726.4	0.039	0.776	0.815	$ 19,120
50717	RANCHO LOS AMIGOS NATL. REHAB. CTR.	7608.2	0.040	0.405	0.445	$ 16,628
50718	VALLEY PLAZA DOCTORS HOSPITAL	4981.7	0.036	0.361	0.397	$ 15,687
50719	THE HEART HOSPITAL	4770.8	0.039	0.365	0.404	$ 15,689
50720	TUSTIN HOSPITAL & MEDICAL CENTER	5078.2	0.039	0.361	0.400	$ 15,993
50721	HOSPITAL NAME NOT AVAILABLE	5057.3	0.036	0.382	0.418	$ 16,627
50722	HOSPITAL NAME NOT AVAILABLE	4979.7	0.036	0.365	0.401	$ 16,373
50723	HOSPITAL NAME NOT AVAILABLE	5057.3	0.036	0.365	0.401	$ 16,628

HISTORY

1. Amendment filed 4-11-79; designated effective 7-1-79 (Register 79, No. 15).

2. Amendment filed 8-14-81; effective thirtieth day thereafter (Register 81, No. 33).

3. Amendment filed 11-5-82; designated effective 1-1-83 (Register 82, No. 45).

4. Amendment filed 11-23-83; effective thirtieth day thereafter (Register 83, No. 48).

5. Amendment filed 8-29-84; effective thirtieth day thereafter (Register 84, No. 35).

6. Editorial correction (Register 84, No. 48).

7. Amendment filed 1-10-85; effective upon filing pursuant to Government Code section 11346.2(d) (Register 85, No. 2).

8. Amendment filed 7-1-87; operative 7-1-87 (Register 87, No. 28).

9. Amendment of section and Note filed 10-7-93; operative 1-1-94 (Register 93, No. 41). This filing is exempt from much of the APA (including OAL review) pursuant to Government Code section 11351.

10. Amendment filed 2/23/99; Effective 4/1/99.

11. Amendment of section and repealer and new Appendices A and B filed 5-30-2001; operative 6-29-2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 23).

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APPENDIX B: DRG WEIGHTS AND REVISED DRG WEIGHTS 2001 Rates

(California revisions shown in italics incorporate the DWC Revised Ratios)

DRG Number	Description	HCFA 2001 DRG Weights	DWC Revised Ratio	DWC Revised Weight	Geometric Mean LOS
1	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.097	1.000	3.097	6.3
2	CRANIOTOMY FOR TRAUMA AGE >17	3.1142	1.000	3.1142	7.3
3	CRANIOTOMY AGE 0-17	1.9629	1.000	1.9629	12.7
4	*SPINAL PROCEDURES*	2.2918	0.628	*1.4399*	4.8
5	EXTRACRANIAL VASCULAR PROCEDURES	1.4321	1.000	1.4321	2.3
6	CARPAL TUNNEL RELEASE	0.8246	1.000	0.8246	2.2
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.5919	1.000	2.5919	6.9
8	*PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC*	1.3948	0.808	*1.1273*	2.1
9	SPINAL DISORDERS & INJURIES	1.3134	1.000	1.3134	4.7
10	NERVOUS SYSTEM NEOPLASMS W CC	1.2273	1.000	1.2273	4.9
11	NERVOUS SYSTEM NEOPLASMS W/O CC	0.8345	1.000	0.8345	3.1
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.8925	1.000	0.8925	4.5
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.7644	1.000	0.7644	4.1
14	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.207	1.000	1.2070	4.7
15	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	0.748	1.000	0.7480	2.9
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.1652	1.000	1.1652	4.7
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.6539	1.000	0.6539	2.6
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.96	1.000	0.9600	4.3
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.6963	1.000	0.6963	2.9
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.7744	1.000	2.7744	7.9
21	VIRAL MENINGITIS	1.4966	1.000	1.4966	5.2
22	HYPERTENSIVE ENCEPHALOPATHY	1.0082	1.000	1.0082	3.8
23	NONTRAUMATIC STUPOR & COMA	0.8027	1.000	0.8027	3.2
24	SEIZURE & HEADACHE AGE >17 W CC	0.9914	1.000	0.9914	3.7

25	*SEIZURE & HEADACHE AGE >17 W/O CC*	0.6043	0.749	*0.4523*	2.6
26	SEIZURE & HEADACHE AGE 0-17	0.6441	1.000	0.6441	2.4
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.2912	1.000	1.2912	3.2
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.3102	1.000	1.3102	4.5
29	*TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC*	0.7015	1.003	*0.7033*	2.8
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.332	1.000	0.3320	2
31	CONCUSSION AGE >17 W CC	0.8715	1.000	0.8715	3.1
32	*CONCUSSION AGE >17 W/O CC*	0.5422	0.875	*0.4744*	2.1
33	CONCUSSION AGE 0-17	0.2086	1.000	0.2086	1.6
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0099	1.000	1.0099	3.8
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6027	1.000	0.6027	2.7
36	RETINAL PROCEDURES	0.6639	1.000	0.6639	1.2
37	ORBITAL PROCEDURES	1.0016	1.000	1.0016	2.6
38	PRIMARY IRIS PROCEDURES	0.4833	1.000	0.4833	1.8
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.5778	1.000	0.5778	1.5
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.8635	1.000	0.8635	2.3
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.338	1.000	0.3380	1.6
42	*INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS*	0.6478	1.066	*0.6906*	1.6
43	HYPHEMA	0.4977	1.000	0.4977	2.6
44	ACUTE MAJOR EYE INFECTIONS	0.6337	1.000	0.6337	4.1
45	NEUROLOGICAL EYE DISORDERS	0.7022	1.000	0.7022	2.7
46	OTHER DISORDERS OF THE EYE AGE >17 W CC	0.7749	1.000	0.7749	3.5
47	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.5085	1.000	0.5085	2.5
48	OTHER DISORDERS OF THE EYE AGE 0-17	0.2977	1.000	0.2977	2.9
49	MAJOR HEAD & NECK PROCEDURES	1.8301	1.000	1.8301	3.5
50	SIALOADENECTOMY	0.8537	1.000	0.8537	1.6
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.7934	1.000	0.7934	1.8
52	CLEFT LIP & PALATE REPAIR	0.841	1.000	0.8410	1.6
53	SINUS & MASTOID PROCEDURES AGE >17	1.2118	1.000	1.2118	2.3
54	SINUS & MASTOID PROCEDURES AGE 0-17	0.4826	1.000	0.4826	3.2
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	0.9039	1.000	0.9039	1.9
56	RHINOPLASTY	0.9451	1.000	0.9451	2.1
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	1.0704	1.000	1.0704	2.5
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.274	1.000	0.2740	1.5
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6943	1.000	0.6943	1.8

60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2087	1.000	0.2087	1.5
61	MYRINGOTOMY W TUBE INSERTION AGE >17	1.266	1.000	1.2660	2.8
62	MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.2955	1.000	0.2955	1.3
63	*OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES*	1.3402	0.875	*1.1731*	3
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2288	1.000	1.2288	4.3
65	DYSEQUILIBRIUM	0.5385	1.000	0.5385	2.3
66	EPISTAXIS	0.559	1.000	0.5590	2.5
67	EPIGLOTTITIS	0.8105	1.000	0.8105	2.8
68	OTITIS MEDIA & URI AGE >17 W CC	0.675	1.000	0.6750	3.4
69	OTITIS MEDIA & URI AGE >17 W/O CC	0.5152	1.000	0.5152	2.7
70	OTITIS MEDIA & URI AGE 0-17	0.4628	1.000	0.4628	2.4
71	LARYNGOTRACHEITIS	0.7712	1.000	0.7712	3
72	NASAL TRAUMA & DEFORMITY	0.6428	1.000	0.6428	2.6
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.7777	1.000	0.7777	3.3
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.3358	1.000	0.3358	2.1
75	MAJOR CHEST PROCEDURES	3.1331	1.000	3.1331	7.8
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.7908	1.000	2.7908	8.4
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.1887	1.000	1.1887	3.5
78	PULMONARY EMBOLISM	1.3698	1.000	1.3698	6
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.6501	1.000	1.6501	6.6
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.9373	1.000	0.9373	4.7
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.5204	1.000	1.5204	6.1
82	RESPIRATORY NEOPLASMS	1.3799	1.000	1.3799	5.2
83	MAJOR CHEST TRAUMA W CC	0.9808	1.000	0.9808	4.4
84	MAJOR CHEST TRAUMA W/O CC	0.5539	1.000	0.5539	2.8
85	PLEURAL EFFUSION W CC	1.2198	1.000	1.2198	4.9
86	PLEURAL EFFUSION W/O CC	0.6984	1.000	0.6984	2.9
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3781	1.000	1.3781	4.8
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.9317	1.000	0.9317	4.2
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0647	1.000	1.0647	5
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.659	1.000	0.6590	3.6
91	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.689	1.000	0.6890	2.8
92	INTERSTITIAL LUNG DISEASE W CC	1.1863	1.000	1.1863	5
93	INTERSTITIAL LUNG DISEASE W/O CC	0.7309	1.000	0.7309	3.3
94	PNEUMOTHORAX W CC	1.1704	1.000	1.1704	4.8
95	PNEUMOTHORAX W/O CC	0.6098	1.000	0.6098	3
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.7871	1.000	0.7871	3.9

97	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5873	1.000	0.5873	3.1
98	BRONCHITIS & ASTHMA AGE 0-17	0.8768	1.000	0.8768	3.2
99	RESPIRATORY SIGNS & SYMPTOMS W CC	0.7117	1.000	0.7117	2.5
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.5437	1.000	0.5437	1.8
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8563	1.000	0.8563	3.3
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.555	1.000	0.5550	2.1
103	HEART TRANSPLANT	excluded	excluded	excluded	excluded
104	CARDIAC VALVE PROCEDURES W CARDIAC CATH	7.1843	1.000	7.1843	8.9
105	CARDIAC VALVE PROCEDURES W/O CARDIAC CATH	5.6567	1.000	5.6567	7.4
106	CORONARY BYPASS W CARDIAC CATH	7.5203	1.000	7.5203	9.3
107	CORONARY BYPASS W/O CARDIAC CATH	5.3762	1.000	5.3762	9.2
108	OTHER CARDIOTHORACIC PROCEDURES	5.6525	1.000	5.6525	8
109	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	4.0198	1.000	4.0198	6.8
110	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.1358	1.000	4.1358	7.1
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.241	1.000	2.2410	4.7
112	*PERCUTANEOUS CARDIOVASCULAR PROCEDURES*	1.8677	0.841	*1.5705*	2.6
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	2.7806	1.000	2.7806	9.8
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.5656	1.000	1.5656	6
115	PERM PACE IMPLNT W AMI,HRT FAIL OR SHOCK OR AICD LEAD OR GEN PROC	3.4711	1.000	3.4711	6
116	OTH PERM CARDIAC PACEMAKER IMPLANT OR PTCA W CORONARY ART STENT	2.419	1.000	2.4190	2.6
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.2966	1.000	1.2966	2.6
118	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.4939	1.000	1.4939	1.9
119	VEIN LIGATION & STRIPPING	1.26	1.000	1.2600	2.9
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.0352	1.000	2.0352	4.9
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP DISCH ALIVE	1.6194	1.000	1.6194	5.5
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP DISCH ALIVE	1.0884	1.000	1.0884	3.3
123	CIRCULATORY DISORDERS W AMI, EXPIRED	1.5528	1.000	1.5528	2.8
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.4134	1.000	1.4134	3.3
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.0606	1.000	1.0606	2.2
126	ACUTE & SUBACUTE ENDOCARDITIS	2.5379	1.000	2.5379	9.3
127	HEART FAILURE & SHOCK	1.013	1.000	1.0130	4.2
128	DEEP VEIN THROMBOPHLEBITIS	0.7651	1.000	0.7651	5
129	CARDIAC ARREST, UNEXPLAINED	1.0968	1.000	1.0968	1.8

130	PERIPHERAL VASCULAR DISORDERS W CC	0.9471	1.000	0.9471	4.7
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5898	1.000	0.5898	3.6
132	ATHEROSCLEROSIS W CC	0.6707	1.000	0.6707	2.4
133	ATHEROSCLEROSIS W/O CC	0.5663	1.000	0.5663	1.9
134	HYPERTENSION	0.5917	1.000	0.5917	2.6
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.9083	1.000	0.9083	3.3
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.6065	1.000	0.6065	2.2
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8192	1.000	0.8192	3.3
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8291	1.000	0.8291	3.1
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5141	1.000	0.5141	2
140	*ANGINA PECTORIS*	0.574	0.783	*0.4497*	2.2
141	SYNCOPE & COLLAPSE W CC	0.7219	1.000	0.7219	2.9
142	SYNCOPE & COLLAPSE W/O CC	0.5552	1.000	0.5552	2.2
143	*CHEST PAIN*	0.5402	0.842	*0.4547*	1.8
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.1668	1.000	1.1668	3.8
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.6322	1.000	0.6322	2.2
146	RECTAL RESECTION W CC	2.743	1.000	2.7430	8.9
147	RECTAL RESECTION W/O CC	1.6221	1.000	1.6221	6
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.4347	1.000	3.4347	10.1
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5667	1.000	1.5667	6.1
150	PERITONEAL ADHESIOLYSIS W CC	2.8523	1.000	2.8523	9.1
151	PERITONEAL ADHESIOLYSIS W/O CC	1.3427	1.000	1.3427	4.8
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9462	1.000	1.9462	6.8
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.208	1.000	1.2080	4.9
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	4.1475	1.000	4.1475	10.1
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.3751	1.000	1.3751	3.3
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	0.8436	1.000	0.8436	6
157	ANAL & STOMAL PROCEDURES W CC	1.2388	1.000	1.2388	3.9
158	ANAL & STOMAL PROCEDURES W/O CC	0.6638	1.000	0.6638	2.1
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.3347	1.000	1.3347	3.8
160	*HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC*	0.7837	0.902	*0.7066*	2.2
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.1017	1.000	1.1017	2.9

162	*INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC*	0.6229	0.867	*0.5402*	1.6
163	HERNIA PROCEDURES AGE 0-17	0.6921	1.000	0.6921	2.4
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.376	1.000	2.3760	7.1
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2838	1.000	1.2838	4.3
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4802	1.000	1.4802	4
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.8937	1.000	0.8937	2.3
168	MOUTH PROCEDURES W CC	1.2141	1.000	1.2141	3.2
169	MOUTH PROCEDURES W/O CC	0.7455	1.000	0.7455	1.9
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.8686	1.000	2.8686	7.7
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1975	1.000	1.1975	3.6
172	DIGESTIVE MALIGNANCY W CC	1.3485	1.000	1.3485	5.1
173	DIGESTIVE MALIGNANCY W/O CC	0.77	1.000	0.7700	2.8
174	G.I. HEMORRHAGE W CC	0.9985	1.000	0.9985	3.9
175	G.I. HEMORRHAGE W/O CC	0.5501	1.000	0.5501	2.5
176	COMPLICATED PEPTIC ULCER	1.1052	1.000	1.1052	4.1
177	UNCOMPLICATED PEPTIC ULCER W CC	0.8998	1.000	0.8998	3.7
178	UNCOMPLICATED PEPTIC ULCER W/O CC	0.6604	1.000	0.6604	2.6
179	INFLAMMATORY BOWEL DISEASE	1.0576	1.000	1.0576	4.7
180	G.I. OBSTRUCTION W CC	0.9423	1.000	0.9423	4.2
181	G.I. OBSTRUCTION W/O CC	0.5304	1.000	0.5304	2.8
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.7922	1.000	0.7922	3.4
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.5717	1.000	0.5717	2.4
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.5119	1.000	0.5119	2.5
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.8621	1.000	0.8621	3.3
186	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.3216	1.000	0.3216	2.9
187	DENTAL EXTRACTIONS & RESTORATIONS	0.7649	1.000	0.7649	2.9
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.1005	1.000	1.1005	4.1
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5796	1.000	0.5796	2.4
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.9884	1.000	0.9884	4.1
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.3914	1.000	4.3914	10.5
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.7916	1.000	1.7916	5.3
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	3.3861	1.000	3.3861	10.3

194	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	1.6191	1.000	1.6191	5.6
195	CHOLECYSTECTOMY W C.D.E. W CC	2.9062	1.000	2.9062	8.3
196	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6593	1.000	1.6593	4.9
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.4544	1.000	2.4544	7.2
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.2339	1.000	1.2339	3.9
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3584	1.000	2.3584	7.2
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	3.2262	1.000	3.2262	7
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.4035	1.000	3.4035	10.2
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3001	1.000	1.3001	4.9
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.325	1.000	1.3250	5
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.2018	1.000	1.2018	4.5
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1.2048	1.000	1.2048	4.7
206	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.6751	1.000	0.6751	3
207	DISORDERS OF THE BILIARY TRACT W CC	1.1032	1.000	1.1032	4
208	DISORDERS OF THE BILIARY TRACT W/O CC	0.6538	1.000	0.6538	2.3
209	*MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY*	2.0912	0.950	*1.9866*	4.6
210	*HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC*	1.8152	1.180	*2.1419*	6
211	*HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC*	1.2647	0.973	*1.2300*	4.5
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	0.8472	1.000	0.8472	11.1
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.7726	1.000	1.7726	6.4
214	*NO LONGER VALID*	0	0.967	*0.0000*	0
215	*NO LONGER VALID*	0	0.956	*0.0000*	0
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	2.2042	1.000	2.2042	7.1
217	*WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS*	2.923	0.572	*1.6711*	8.9
218	*LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC*	1.5337	1.030	*1.5794*	4.2
219	*LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC*	1.0255	0.968	*0.9928*	2.7
	LOWER EXTREM & HUMER PROC EXCEPT				

220	HIP,FOOT,FEMUR AGE 0-17	0.5844	1.000	0.5844	5.3
221	*NO LONGER VALID*	0	0.818	*0.0000*	0
222	*NO LONGER VALID*	0	1.038	*0.0000*	0
223	*MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC*	0.9585	0.885	*0.8483*	2
224	*SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC*	0.7997	1.012	*0.8095*	1.7
225	*FOOT PROCEDURES*	1.0851	1.001	*1.0860*	3.3
226	SOFT TISSUE PROCEDURES W CC	1.477	1.000	1.4770	4.3
227	*SOFT TISSUE PROCEDURES W/O CC*	0.8036	0.944	*0.7588*	2.1
228	*MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC*	1.0664	0.906	*0.9665*	2.4
229	*HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC*	0.7169	1.037	*0.7432*	1.8
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.249	1.000	1.2490	3.4
231	*LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR*	1.3825	0.734	*1.0149*	3.2
232	*ARTHROSCOPY*	1.0828	0.817	*0.8842*	2.3
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.089	1.000	2.0890	5.3
234	*OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC*	1.2661	0.813	*1.0297*	2.7
235	FRACTURES OF FEMUR	0.7582	1.000	0.7582	3.8
236	*FRACTURES OF HIP & PELVIS*	0.7218	0.979	*0.7066*	4
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.5681	1.000	0.5681	3
238	OSTEOMYELITIS	1.3496	1.000	1.3496	6.4
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	0.9745	1.000	0.9745	4.9
240	CONNECTIVE TISSUE DISORDERS W CC	1.2712	1.000	1.2712	4.9
241	CONNECTIVE TISSUE DISORDERS W/O CC	0.6177	1.000	0.6177	3.1
242	SEPTIC ARTHRITIS	1.0724	1.000	1.0724	5.1
243	*MEDICAL BACK PROBLEMS*	0.7262	0.761	*0.5526*	3.7
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.7155	1.000	0.7155	3.7
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4832	1.000	0.4832	2.8
246	NON-SPECIFIC ARTHROPATHIES	0.557	1.000	0.5570	2.9
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5696	1.000	0.5696	2.6
248	TENDONITIS, MYOSITIS & BURSITIS	0.7864	1.000	0.7864	3.7
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.6913	1.000	0.6913	2.6
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE	0.6929	1.000	0.6929	3.3

	>17 W CC				
251	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC*	0.4995	0.901	*0.4501*	2.4
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.2538	1.000	0.2538	1.8
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.7253	1.000	0.7253	3.7
254	*FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC*	0.4413	1.003	*0.4427*	2.6
255	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	0.2956	1.000	0.2956	2.9
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.7959	1.000	0.7959	3.8
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9107	1.000	0.9107	2.3
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7232	1.000	0.7232	1.8
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9068	1.000	0.9068	1.8
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.6532	1.000	0.6532	1.3
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	0.9362	1.000	0.9362	1.7
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.8754	1.000	0.8754	2.7
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.1219	1.000	2.1219	8.9
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.1479	1.000	1.1479	5.4
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.5309	1.000	1.5309	4.3
266	*SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC*	0.8707	1.131	*0.9844*	2.4
267	PERIANAL & PILONIDAL PROCEDURES	1.0792	1.000	1.0792	3.1
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.1405	1.000	1.1405	2.4
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.7004	1.000	1.7004	5.8
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.767	1.000	0.7670	2.3
271	SKIN ULCERS	1.0104	1.000	1.0104	5.5
272	MAJOR SKIN DISORDERS W CC	0.9994	1.000	0.9994	4.8
273	MAJOR SKIN DISORDERS W/O CC	0.6179	1.000	0.6179	3.2
274	MALIGNANT BREAST DISORDERS W CC	1.2061	1.000	1.2061	4.9
275	MALIGNANT BREAST DISORDERS W/O CC	0.5301	1.000	0.5301	2.4
276	NON-MALIGANT BREAST DISORDERS	0.6899	1.000	0.6899	3.6
277	*CELLULITIS AGE >17 W CC*	0.8396	0.791	*0.6641*	4.7
278	*CELLULITIS AGE >17 W/O CC*	0.5522	0.865	*0.4779*	3.6
279	CELLULITIS AGE 0-17	0.6644	1.000	0.6644	4.2
	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17				

280	W CC	0.6788	1.000	0.6788	3.2
281	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC*	0.4729	0.971	*0.4591*	2.4
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.257	1.000	0.2570	2.2
283	MINOR SKIN DISORDERS W CC	0.6917	1.000	0.6917	3.5
284	MINOR SKIN DISORDERS W/O CC	0.4336	1.000	0.4336	2.5
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	1.9961	1.000	1.9961	7.7
286	ADRENAL & PITUITARY PROCEDURES	2.1299	1.000	2.1299	4.9
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.8283	1.000	1.8283	7.8
288	O.R. PROCEDURES FOR OBESITY	2.1607	1.000	2.1607	4.5
289	PARATHYROID PROCEDURES	0.9914	1.000	0.9914	2
290	THYROID PROCEDURES	0.9193	1.000	0.9193	1.8
291	THYROGLOSSAL PROCEDURES	0.5487	1.000	0.5487	1.4
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.4538	1.000	2.4538	6.9
293	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.2289	1.000	1.2289	3.6
294	DIABETES AGE >35	0.7589	1.000	0.7589	3.6
295	DIABETES AGE 0-35	0.7587	1.000	0.7587	2.9
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.8594	1.000	0.8594	4
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5179	1.000	0.5179	2.8
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.5269	1.000	0.5269	2.5
299	INBORN ERRORS OF METABOLISM	0.9632	1.000	0.9632	4
300	ENDOCRINE DISORDERS W CC	1.0829	1.000	1.0829	4.7
301	ENDOCRINE DISORDERS W/O CC	0.6133	1.000	0.6133	2.9
302	KIDNEY TRANSPLANT	excluded	excluded	excluded	excluded
303	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.4602	1.000	2.4602	7
304	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	2.3407	1.000	2.3407	6.4
305	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.1825	1.000	1.1825	3.1
306	PROSTATECTOMY W CC	1.2489	1.000	1.2489	3.7
307	PROSTATECTOMY W/O CC	0.646	1.000	0.6460	1.9
308	MINOR BLADDER PROCEDURES W CC	1.6449	1.000	1.6449	4.2
309	MINOR BLADDER PROCEDURES W/O CC	0.9339	1.000	0.9339	2
310	TRANSURETHRAL PROCEDURES W CC	1.1172	1.000	1.1172	3
311	TRANSURETHRAL PROCEDURES W/O CC	0.6174	1.000	0.6174	1.6
312	URETHRAL PROCEDURES, AGE >17 W CC	1.0173	1.000	1.0173	3
313	URETHRAL PROCEDURES, AGE >17 W/O CC	0.6444	1.000	0.6444	1.7

314	URETHRAL PROCEDURES, AGE 0-17	0.4953	1.000	0.4953	2.3
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0474	1.000	2.0474	4.2
316	RENAL FAILURE	1.3424	1.000	1.3424	4.9
317	ADMIT FOR RENAL DIALYSIS	0.7395	1.000	0.7395	2.1
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1313	1.000	1.1313	4.3
319	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.604	1.000	0.6040	2.2
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.8621	1.000	0.8621	4.3
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5686	1.000	0.5686	3.2
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.4939	1.000	0.4939	3.3
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.7996	1.000	0.7996	2.4
324	URINARY STONES W/O CC	0.4509	1.000	0.4509	1.6
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.646	1.000	0.6460	3
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4297	1.000	0.4297	2.1
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.3543	1.000	0.3543	3.1
328	URETHRAL STRICTURE AGE >17 W CC	0.7455	1.000	0.7455	2.8
329	URETHRAL STRICTURE AGE >17 W/O CC	0.5253	1.000	0.5253	1.7
330	URETHRAL STRICTURE AGE 0-17	0.3191	1.000	0.3191	1.6
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0221	1.000	1.0221	4.1
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.5997	1.000	0.5997	2.5
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.8247	1.000	0.8247	3.5
334	MAJOR MALE PELVIC PROCEDURES W CC	1.5591	1.000	1.5591	4.2
335	MAJOR MALE PELVIC PROCEDURES W/O CC	1.1697	1.000	1.1697	3.2
336	TRANSURETHRAL PROSTATECTOMY W CC	0.888	1.000	0.8880	2.7
337	TRANSURETHRAL PROSTATECTOMY W/O CC	0.6152	1.000	0.6152	1.9
338	TESTES PROCEDURES, FOR MALIGNANCY	1.19	1.000	1.1900	3.5
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.0769	1.000	1.0769	3
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.2835	1.000	0.2835	2.4
341	PENIS PROCEDURES	1.1709	1.000	1.1709	2.1
342	CIRCUMCISION AGE >17	0.824	1.000	0.8240	2.5
343	CIRCUMCISION AGE 0-17	0.1541	1.000	0.1541	1.7
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.1519	1.000	1.1519	1.6
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	0.88	1.000	0.8800	2.6
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.9756	1.000	0.9756	4.3
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5922	1.000	0.5922	2.4

348	BENIGN PROSTATIC HYPERTROPHY W CC	0.7142	1.000	0.7142	3.2
349	BENIGN PROSTATIC HYPERTROPHY W/O CC	0.438	1.000	0.4380	2
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.6992	1.000	0.6992	3.6
351	STERILIZATION, MALE	0.2364	1.000	0.2364	1.3
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.6858	1.000	0.6858	2.8
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.9292	1.000	1.9292	5.3
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.5284	1.000	1.5284	4.9
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	0.9278	1.000	0.9278	3.1
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.7846	1.000	0.7846	2.1
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	2.3628	1.000	2.3628	6.9
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.2263	1.000	1.2263	3.7
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	0.8593	1.000	0.8593	2.6
360	VAGINA, CERVIX & VULVA PROCEDURES	0.886	1.000	0.8860	2.4
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.2318	1.000	1.2318	2.2
362	ENDOSCOPIC TUBAL INTERRUPTION	0.3022	1.000	0.3022	1.4
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.8136	1.000	0.8136	2.5
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.753	1.000	0.7530	2.6
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.8425	1.000	1.8425	4.9
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2467	1.000	1.2467	4.8
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.5676	1.000	0.5676	2.4
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.1205	1.000	1.1205	5
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.5704	1.000	0.5704	2.4
370	CESAREAN SECTION W CC	1.0631	1.000	1.0631	4.4
371	CESAREAN SECTION W/O CC	0.7157	1.000	0.7157	3.3
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.6077	1.000	0.6077	2.7
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.4169	1.000	0.4169	2
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.7565	1.000	0.7565	2.6
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.686	1.000	0.6860	4.4
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.5224	1.000	0.5224	2.6
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	0.8899	1.000	0.8899	2.6
378	ECTOPIC PREGNANCY	0.7664	1.000	0.7664	2

379	THREATENED ABORTION	0.3959	1.000	0.3959	2
380	ABORTION W/O D&C	0.4843	1.000	0.4843	1.8
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.5331	1.000	0.5331	1.5
382	FALSE LABOR	0.2127	1.000	0.2127	1.3
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.5137	1.000	0.5137	2.7
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.3161	1.000	0.3161	1.6
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.3767	1.000	1.3767	1.8
386	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	4.54	1.000	4.5400	17.9
387	PREMATURITY W MAJOR PROBLEMS	3.1007	1.000	3.1007	13.3
388	PREMATURITY W/O MAJOR PROBLEMS	1.8709	1.000	1.8709	8.6
389	FULL TERM NEONATE W MAJOR PROBLEMS	1.8408	1.000	1.8408	4.7
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	0.9471	1.000	0.9471	3
391	NORMAL NEWBORN	0.1527	1.000	0.1527	3.1
392	SPLENECTOMY AGE >17	3.1739	1.000	3.1739	7.1
393	SPLENECTOMY AGE 0-17	1.3486	1.000	1.3486	9.1
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.5969	1.000	1.5969	4.1
395	RED BLOOD CELL DISORDERS AGE >17	0.8257	1.000	0.8257	3.3
396	RED BLOOD CELL DISORDERS AGE 0-17	1.1573	1.000	1.1573	2.5
397	COAGULATION DISORDERS	1.2278	1.000	1.2278	3.8
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.275	1.000	1.2750	4.7
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.6881	1.000	0.6881	2.8
400	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.6309	1.000	2.6309	5.8
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.7198	1.000	2.7198	7.8
402	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	1.0985	1.000	1.0985	2.8
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.7594	1.000	1.7594	5.7
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.848	1.000	0.8480	3.1
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.912	1.000	1.9120	4.9
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	2.8275	1.000	2.8275	7.6
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.3179	1.000	1.3179	3.6
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	2.0008	1.000	2.0008	4.8

409	RADIOTHERAPY	1.1215	1.000	1.1215	4.4
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	0.9468	1.000	0.9468	2.9
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.3305	1.000	0.3305	2
412	HISTORY OF MALIGNANCY W ENDOSCOPY	0.4841	1.000	0.4841	2
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3645	1.000	1.3645	5.3
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.7548	1.000	0.7548	3
415	*O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES*	3.5925	0.491	*1.7628*	10.4
416	SEPTICEMIA AGE >17	1.5278	1.000	1.5278	5.5
417	SEPTICEMIA AGE 0-17	1.1717	1.000	1.1717	3.7
418	*POSTOPERATIVE & POST-TRAUMATIC INFECTIONS*	1.0074	0.680	*0.6851*	4.8
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.8709	1.000	0.8709	3.7
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.6057	1.000	0.6057	3
421	VIRAL ILLNESS AGE >17	0.6796	1.000	0.6796	3.1
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.7854	1.000	0.7854	2.8
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.725	1.000	1.7250	5.9
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	excluded	excluded	excluded	excluded
425	ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	excluded	excluded	excluded	excluded
426	DEPRESSIVE NEUROSES	excluded	excluded	excluded	excluded
427	NEUROSES EXCEPT DEPRESSIVE	excluded	excluded	excluded	excluded
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL	excluded	excluded	excluded	excluded
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	excluded	excluded	excluded	excluded
430	PSYCHOSES	excluded	excluded	excluded	excluded
431	CHILDHOOD MENTAL DISORDERS	excluded	excluded	excluded	excluded
432	OTHER MENTAL DISORDER DIAGNOSES	excluded	excluded	excluded	excluded
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	excluded	excluded	excluded	excluded
434	ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC	excluded	excluded	excluded	excluded
435	ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W/O CC	excluded	excluded	excluded	excluded
436	ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	excluded	excluded	excluded	excluded
437	ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY	excluded	excluded	excluded	excluded
438	NO LONGER VALID	0	1.000	0.0000	0
439	SKIN GRAFTS FOR INJURIES	1.7092	1.000	1.7092	5.3
440	*WOUND DEBRIDEMENTS FOR INJURIES*	1.9096	0.774	*1.4776*	5.8
441	*HAND PROCEDURES FOR INJURIES*	0.9463	0.991	*0.9382*	2.2
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.3403	1.000	2.3403	5.4

443	*OTHER O.R. PROCEDURES FOR INJURIES W/O CC*	0.9978	1.002	*1.0002*	2.5
444	TRAUMATIC INJURY AGE >17 W CC	0.7243	1.000	0.7243	3.2
445	*TRAUMATIC INJURY AGE >17 W/O CC*	0.5076	0.811	*0.4118*	2.4
446	TRAUMATIC INJURY AGE 0-17	0.2964	1.000	0.2964	2.4
447	ALLERGIC REACTIONS AGE >17	0.5166	1.000	0.5166	1.9
448	ALLERGIC REACTIONS AGE 0-17	0.0975	1.000	0.0975	2.9
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.8076	1.000	0.8076	2.6
450	*POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC*	0.4406	0.666	*0.2933*	1.6
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.2632	1.000	0.2632	2.1
452	COMPLICATIONS OF TREATMENT W CC	1.0152	1.000	1.0152	3.5
453	COMPLICATIONS OF TREATMENT W/O CC	0.4987	1.000	0.4987	2.2
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.8593	1.000	0.8593	3.2
455	*OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC*	0.4672	0.748	*0.3496*	2
456	**NO LONGER VALID** ~~BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY~~	**0** ~~excluded~~	**0** ~~excluded~~	**0** ~~excluded~~	**0** ~~excluded~~
457	**NO LONGER VALID** ~~EXTENSIVE BURNS W/O O.R. PROCEDURE~~	**0** ~~excluded~~	**0** ~~excluded~~	**0** ~~excluded~~	**0** ~~excluded~~
458	**NO LONGER VALID** ~~NON-EXTENSIVE BURNS W SKIN GRAFT~~	**0** ~~excluded~~	**0** ~~excluded~~	**0** ~~excluded~~	**0** ~~excluded~~
459	**NO LONGER VALID** ~~NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC~~	**0** ~~excluded~~	**0** ~~excluded~~	**0** ~~excluded~~	**0** ~~excluded~~
460	**NO LONGER VALID** ~~NON-EXTENSIVE BURNS W/O O.R. PROCEDURE~~	**0** ~~excluded~~	**0** ~~excluded~~	**0** ~~excluded~~	**0** ~~excluded~~
461	*O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES*	1.2101	0.921	*1.1141*	2.4
462	REHABILITATION	excluded	excluded	excluded	excluded
463	SIGNS & SYMPTOMS W CC	0.6936	1.000	0.6936	3.3
464	SIGNS & SYMPTOMS W/O CC	0.4775	1.000	0.4775	2.4
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.5756	1.000	0.5756	2.1
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.684	1.000	0.6840	2.3
467	OTHER FACTORS INFLUENCING HEALTH STATUS	0.5112	1.000	0.5112	2.3
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.6399	1.000	3.6399	9.2
469	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0	1.000	0.0000	0
470	UNGROUPABLE	0	1.000	0.0000	0
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	3.1957	1.000	3.1957	5
472	**NO LONGER VALID** ~~EXTENSIVE BURNS W O.R. PROCEDURE~~	**0** ~~excluded~~	**0** ~~excluded~~	**0** ~~excluded~~	**0** ~~excluded~~
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.5822	1.000	3.5822	7.6

474	NO LONGER VALID	0	1.000	0.0000	0
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	excluded	excluded	excluded	excluded
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.2547	1.000	2.2547	8.4
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.8204	1.000	1.8204	5.4
478	OTHER VASCULAR PROCEDURES W CC	2.3333	1.000	2.3333	4.9
479	OTHER VASCULAR PROCEDURES W/O CC	1.4326	1.000	1.4326	2.8
480	LIVER TRANSPLANT	excluded	excluded	excluded	excluded
481	BONE MARROW TRANSPLANT	excluded	excluded	excluded	excluded
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	excluded	excluded	excluded	excluded
483	TRACHEOSTOMY EXCEPT FOR FACE,MOUTH & NECK DIAGNOSES	excluded	excluded	excluded	excluded
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.5606	1.000	5.5606	8.8
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR	3.0998	1.000	3.0998	7.7
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.9048	1.000	4.9048	8.1
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	2.0604	1.000	2.0604	5.6
488	HIV W EXTENSIVE O.R. PROCEDURE	4.5574	1.000	4.5574	11.5
489	HIV W MAJOR RELATED CONDITION	1.7414	1.000	1.7414	6
490	HIV W OR W/O OTHER RELATED CONDITION	0.968	1.000	0.9680	3.7
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.6685	1.000	1.6685	2.9
492	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	4.2467	1.000	4.2467	10.9
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.818	1.000	1.8180	4.3
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0388	1.000	1.0388	2
495	LUNG TRANSPLANT	excluded	excluded	excluded	excluded
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION Note – For admissions on or after * , 2000, the cost of implantable hardware and instrumentation for this DRG is excluded from the DRG computed fee and reimbursed separately pursuant to § 9792.1(c)(9).	5.5532	1.000	5.5532	7.8
497	SPINAL FUSION W CC Note – For admissions on or after * , 2000, the cost of implantable hardware and instrumentation for this DRG is excluded from the DRG computed fee and reimbursed separately pursuant to § 9792.1(c)(9).	2.9441	1.000	2.9441	4.9
498	SPINAL FUSION W/O CC Note – For admissions on or after * , 2000, the cost of implantable hardware and instrumentation for this DRG is excluded from the DRG computed fee and reimbursed separately pursuant to § 9792.1(c)(9).	1.9057	1.000	1.9057	2.8
	BACK & NECK PROCS EXCEPT SPINAL FUSION W CC Note – For admissions on or after * , 2000, the cost of implantable				

499	hardware and instrumentation for this DRG is excluded from the DRG computed fee and reimbursed separately pursuant to § 9792.1(c)(9).	1.4572	1.000	1.4572	3.6
500	BACK & NECK PROCS EXCEPT SPINAL FUSION W/O CC Note – For admissions on or after * , 2000, the cost of implantable hardware and instrumentation for this DRG is excluded from the DRG computed fee and reimbursed separately pursuant to § 9792.1(c)(9).	0.9805	1.000	0.9805	2.2
501	KNEE PROC W PDX OF INFECTION W CC	2.6283	1.000	2.6283	8.4
502	KNEE PROC W PDX OF INFECTION W/O CC	1.4434	1.000	1.4434	4.9
503	KNEE PROCEDURES W/O PDX OF INFECTION	1.2156	1.000	1.2156	3.1
504	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	excluded	excluded	excluded	excluded
505	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT.	excluded	excluded	excluded	excluded
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	excluded	excluded	excluded	excluded
507	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC OR SIG TRAUMA.	excluded	excluded	excluded	excluded
508	FULL THICKNESS BURN W/O SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	excluded	excluded	excluded	excluded
509	FULL THICKNESS BURN W/O SKIN GRAFT OR INHAL INJ W/O CC OR SIG TRAUMA.	excluded	excluded	excluded	excluded
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	excluded	excluded	excluded	excluded
511	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA.	excluded	excluded	excluded	excluded

Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 5.5. Application of the Official Medical Fee Schedule (Treatment)

New query

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§9792. Determination of the Fee.

APPENDIX C: RATIOS APPLIED TO REVISE CERTAIN DRG WEIGHTS IN CALIFORNIA

APPENDIX C: RATIOS APPLIED TO REVISE CERTAIN DRG WEIGHTS IN CALIFORNIA

Number	DRG	Ratio
004	Spinal Procs	0.6283
008	Peripheral/Cranial Nerve & Orth OR Nervous Sys. Procs	0.8082
025	Seizures and Headaches: AD WO CC	0.7485
029	Traumatic Stupor and Coma: AD WO CC	1.0025
032	Concussion: AD WO CC	0.8749
042	Intraocular Proc Exc. Retina, Iris and Lens	1.0661
063	Other Ear, Nose, Mouth and Throat OR Procs	0.8753
112	Percutaneous Cardiovascular Procs	0.8409
140	Angina Pectoris	0.7834
143	Chest Pain	0.8417
160	Hernia Proc: AD Exc. Inguinal or Femoral, WO CC	0.9016
162	Hernia Proc: AD Inguinal or Femoral, WO CC	0.8672
209	Major Joints and Limb Reattachment, Lower Extremity	0.9500
210	Hip and Femur, Exc Major joint Proc: AD W CC	1.1800
211	Hip and Femur, Exc Major joint Proc: AD WO CC	0.9726
214	Back and Neck Proc W CC	0.9674
215	Back and Neck Procs WO CC	0.9556
217	Wound Debridement and Skin Graft Exc. Hand	0.5717
218	Lower Extr/Humerous Exc. Hip, Foot and Femur: AD W CC	1.0298
219	Lower Extr/Humer. Exc. Hip, Foot and Femur: AD WO CC	0.9681
221	Knee Proc W CC	0.8177
222	Knee Proc WO CC	1.0382
223	Maj. Shoulder/Elbow Proc/Other Upper Extrem. Proc W CC	0.8850
224	Shoulder/Elbow/Forearm Proc exc. Major Joint Proc WO CC	1.0122
225	Foot Proc	1.0008
227	Soft Tissue Proc WO CC	0.9443
228	Major Thumb/Joint Proc, or Other Hand or Wrist Proc W CC	0.9063

229	Hand and Wrist Proc, Exc. Major joint Proc WO CC	1.0367
231	Local Excision/Removal Int. Fix. Devices Exc. Hip & Femur	0.7341
232	Arthroscopy	0.8166
234	Oth. Musculoskel. Sys/Connective Tissue OR Procs WO CC	0.8133
236	Fracture of Hip and Pelvis	0.9790
243	Medical Back	0.7609
251	Frac, Sprain, Strain, Disloc Forearm, Hand/Foot: AD WO CC	0.9012
254	Frac, Sprain, Strain, Disloc Up Arm/Low Leg ex Foot: AD W CC	1.0031
266	Skin Graft/Debridement Exc. Skin Ulcer or Cellulitis WO CC	1.1306
277	Cellulitis: AD W CC	0.7910
278	Cellulitis: AD WO CC	0.8654
281	Trauma to Skin, Subcutaneous Tiss and Breast: AD WO CC	0.9709
415	Infectious and Parasitic Disease OR Proc	0.4907
418	Postoperative and Post traumatic Infection	0.6801
440	Wound Debridement for Injury	0.7738
441	Hand Proc for Injury	0.9914
443	Other Proc for Injury WO CC	1.0024
445	Traumatic Injury: AD WO CC	0.8112
450	Injury/Poison/Drug: AD WO CC	0.6657
455	Other Injury/Poisoning and Toxic Effect Diagnosis WO CC	0.7483
461	OR Proc with Diagnosis of Other Contact with Health Services	0.9207

HISTORY

1. New Section filed with OAL on 2/23/99; Effective 4/1/99.

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Article 5.5. Application of the Official Medical Fee Schedule (Treatment)

New query

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§9792.5. Payment for Medical Treatment.

(a) As used in this section:

(1) “Claims Administrator” has the same meaning specified in Section 9785(a)(3).

(2) “Medical treatment” means the treatment to which an employee is entitled under Labor Code Section 4600.

(3) “Physician” has the same meaning specified in Labor Code Section 3209.3.

(4) “Required report” means a report which must be submitted pursuant to Section 9785.

(5) “Treating physician” means the “primary treating physician” as that term is defined by Section 9785(a)(1).

(b) Any properly documented bill for medical treatment within the planned course, scope and duration of treatment reported under Section 9785 which is provided or authorized by the treating physician shall be paid by the claims administrator within sixty days from receipt of each separate itemized bill and any required reports, unless the bill is contested, as specified in subdivisions (d), and (e), within thirty working days of receipt of the bill. Any amount not contested within the thirty working days or not paid within the sixty day period shall be increased 10%, and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill.

For purposes of this Section, treatment which is provided or authorized by the treating physician includes but is not limited to treatment provided by a “secondary physician” as that term is defined by Section 9785(a)(2).

(c) To be properly documented, a bill for medical treatment which exceeds the amount presumed reasonable in the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1, must be accompanied by an itemization and explanation for the excess charge.

(d) A claims administrator who objects to all or any part of a bill for medical treatment shall notify the physician or other authorized provider of the objection within thirty working days after receipt of the bill and any required report and shall pay any uncontested amount within sixty days after receipt of the bill. If a required report is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill or report, whichever is received later. If the claims administrator receives a bill and believes that it has not received a required report to support the bill, the claims administrator shall so inform the medical provider within thirty working days of receipt of the bill. An objection will be deemed timely if sent by first class mail and postmarked on or before the thirtieth working day after receipt, or if personally delivered or sent by electronic facsimile on or before the thirtieth working day after receipt. Any notice of objection shall include or be accompanied by all of the following:

(1) An explanation of the basis for the objection to each contested procedure and charge. The original procedure codes used by the physician or authorized provider shall not be altered. If the objection is based on appropriate coding of a procedure, the explanation shall include both the code reported by the provider and the code believed reasonable by the claims administrator.

(2) If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the information required.

(3) The name, address, and telephone number of the person or office to contact for additional information concerning the objection.

(4) A statement that the treating physician or authorized provider may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board.

(e) An objection to charges from a hospital, outpatient surgery center, or independent diagnostic facility shall be deemed sufficient if the provider is advised, within the thirty working day period specified in subdivision (d), that a request has been made for an audit of the billing, when the results of the audit are expected, and contains the name, address, and telephone number of the person or office to contact for additional information concerning the audit.

(f) Any contested charge for medical treatment provided or authorized by the treating physician which is determined by the appeals board to be payable shall carry interest at the same rate as judgments in civil actions from the date the amount was due until it is paid.

NOTE

Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 4603.2 and 5307.1, Labor Code.

HISTORY

1. New section filed 4-13-93; operative 4-13-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 16).

2. Amendment of subsections (b), (d), (d)(1), (f) and (g) filed 9-25-95; operative 9-25-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 39).

3. Change without regulatory effect amending section and Note filed 6-12-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 24).

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Article 5.5.1. Utilization Review Standards

New query

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§9792.6. Utilization Review Standards.

As used in this Article:

(a) “ACOEM Practice Guidelines” means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition.

(b) “Authorization” means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on the Doctor's First Report of Occupational Injury or Illness,” Form DLSR 5021, or on the “Primary Treating Physician's Progress Report,” DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the DWC Form PR-2.

(c) “Claims Administrator” is a self-administered workers' compensation insurer, an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610. The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.

(d) “Concurrent review” means utilization review conducted during an inpatient stay.

(e) “Course of treatment” means the course of medical treatment set forth in the treatment plan contained on the “Doctor's First Report of Occupational Injury or Illness,” Form DLSR 5021, or on the “Primary Treating Physician's Progress Report,” DWC Form PR-2, as contained in section 9785.2 or in narrative form containing the same information required in the DWC Form PR-2.

(f) “Emergency health care services” means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

(g) “Expedited review” means utilization review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

(h) “Expert reviewer” means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.

(i) “Health care provider” means a provider of medical services, as well as related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization or medical provider network as provided in Labor Code section 4616.

(j) “Immediately” means within 24 hours after learning the circumstances that would require an extension of the timeframe for decisions specified in subdivisions (b)(1), (b)(2) or (c) and (g)(1) of section 9792.9.

(k) “Material modification” is when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

(l) “Medical Director” is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California. The Medical Director is responsible for all decisions made in the utilization review process.

(m) “Medical services” means those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

(n) “Prospective review” means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services.

(o) “Request for authorization” means a written confirmation of an oral request for a specific course of proposed medical treatment pursuant to Labor Code section 4610(h) or a written request for a specific course of proposed medical treatment. An oral request for authorization must be followed by a written confirmation of the request within seventy-two (72) hours. Both the written confirmation of an oral request and the written request must be set forth on the “Doctor's First Report of Occupational Injury or Illness,” Form DLSR 5021, section 14006, or on the Primary Treating Physician Progress Report, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the PR-2 form. If a narrative format is used, the document shall be clearly marked at the top that it is a request for authorization.

(p) “Retrospective review” means utilization review conducted after medical services have been provided and for which approval has not already been given.

(q) “Reviewer” means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's practice.

(r) “Utilization review plan” means the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization review process.

(s) “Utilization review process” means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. Utilization review does not include determinations of the work-relatedness of injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed.

(t) “Written” includes a facsimile as well as communications in paper form.

NOTE

Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 3209.3, 4062, 4600, 4600.4, 4604.5 and 4610, Labor Code.

HISTORY

1. New section filed 7-20-95; operative 7-20-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 29).

2. Amendment of subsections (a)(4), (c)(1), (c)(3)(iii)-(iv) and (c)(4)(i)-(iii) filed 11-9-98; operative 1-1-99 (Register 98, No. 46).

3. New article 5.5.1 (sections 9792.6-9792.11) and repealer and new section filed 12-9-2004 as an emergency; operative 12-13-2004 (Register 2004, No. 50). A Certificate of Compliance must be transmitted to OAL by 4-12-2005 or emergency language will be repealed by operation of law on the following day.

4. New article 5.5.1 (sections 9792.6-9792.11) and repealer and new section refiled 4-6-2005 as an emergency; operative 4-12-2005 (Register 2005, No. 14). A Certificate of Compliance must be transmitted to OAL by 8-10-2005 or emergency language will be repealed by operation of law on the following day.

5. Certificate of Compliance as to 4-6-2005 order, including amendment of section and Note, transmitted to OAL 8-10-2005 and filed 9-22-2005 (Register 2005, No. 38).

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New query

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§9792.7. Utilization Review Standards--Applicability

(a) Effective January 1, 2004, every claims administrator shall establish and maintain a utilization review process for treatment rendered on or after January 1, 2004, regardless of date of injury, in compliance with Labor Code section 4610. Each utilization review process shall be set forth in a utilization review plan which shall contain:

(1) The name, address, phone number, and medical license number of the employed or designated medical director, who holds an unrestricted license to practice medicine in the state of California issued pursuant to section 2050 or section 2450 of the Business and Professions Code.

(2) A description of the process whereby requests for authorization are reviewed, and decisions on such requests are made, and a description of the process for handling expedited reviews.

(3) A description of the specific criteria utilized routinely in the review and throughout the decision-making process, including treatment protocols or standards used in the process. A description of the personnel and other sources used in the development and review of the criteria, and methods for updating the criteria. Prior to and until the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, the written policies and procedures governing the utilization review process shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition. The Administrative Director incorporates by reference the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM), Second Edition (2004), published by OEM Press. A copy may be obtained from OEM Press, 8 West Street, Beverly Farms, Massachusetts 01915 (www.oempress.com). After the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, the written policies and procedures governing the utilization review process shall be consistent with the recommended standards set forth in that schedule.

(4) A description of the qualifications and functions of the personnel involved in decision-making and implementation of the utilization review plan.

(5) A description of the claims administrator's practice, if applicable, of any prior authorization process, including but not limited to, where authorization is provided without the submission of the request for authorization.

(b)(1) The medical director shall ensure that the process by which the claims administrator reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical services, complies with Labor Code section 4610 and these implementing regulations.

(2) A reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the reviewer's scope of practice, may, except as indicated below, delay, modify or deny, requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

(3) A non-physician reviewer may be used to initially apply specified criteria to requests for authorization for medical services. A non-physician reviewer may approve requests for authorization of medical services. A non-physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization. Additionally, a non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision but in no event shall this exceed the time limitations imposed in section 9792.9 subdivisions (b)(1), (b)(2) or (c). Any time beyond the time specified in these paragraphs is subject to the provisions of subdivision (g)(1)(A) through (g)(1)(C) of section 9792.9.

(c) The complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process, shall be filed by the claims administrator, or by the external utilization review organization contracted by the claims administrator to perform the utilization review, with the Administrative Director. In lieu of filing the utilization review plan, the claims administrator may submit a letter identifying the external utilization review organization which has been contracted to perform the utilization review functions, provided that the utilization review organization has filed a complete utilization review plan with the Administrative Director. A modified utilization review plan shall be filed with the Administrative Director within 30 calendar days after the claims administrator makes a material modification to the plan.

(d) Upon request by the public, the claims administrator shall make available the complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process.

(1) The claims administrator may make available the complete utilization review plan, consisting of the policies and procedures and a description of the utilization review process, through electronic means. If a member of the public requests a hard copy of the utilization review plan, the claims administrator may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed $0.25 per page plus actual postage costs.

NOTE

Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 4062, 4600, 4600.4, 4604.5 and 4610, Labor Code.

HISTORY

1. New section filed 12-9-2004 as an emergency; operative 12-13-2004 (Register 2004, No. 50). A Certificate of Compliance must be transmitted to OAL by 4-12-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 4-6-2005 as an emergency; operative 4-12-2005 (Register 2005, No. 14). A Certificate of Compliance must be transmitted to OAL by 8-10-2005 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 4-6-2005 order, including amendment of section, transmitted to OAL 8-10-2005 and filed 9-22-2005 (Register 2005, No. 38).

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§9792.8. Utilization Review Standards--Medically-Based Criteria.

(a)(1) The criteria shall be consistent with the schedule for medical treatment utilization adopted pursuant to Labor Code section 5307.27. Prior to adoption of the schedule, the criteria or guidelines used in the utilization review process shall be consistent with the American College of Occupational and Environmental Medicine's (ACOEM) Practice Guidelines, Second Edition. The guidelines set forth in the ACOEM Practice Guidelines shall be presumptively correct on the issue of extent and scope of medical treatment until the effective date of the utilization schedule adopted pursuant to Labor Code section 5307.27. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury.

(2) For all conditions or injuries not addressed by the ACOEM Practice Guidelines or by the official utilization schedule after adoption pursuant to Labor Code section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based. Treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines until adoption of the medical treatment utilization schedule pursuant to Labor Code section 5307.27. After the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, treatment may not be denied on the sole basis that the treatment is not addressed by that schedule.

(3) The relevant portion of the criteria or guidelines used shall be disclosed in written form to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, if used as the basis of a decision to modify, delay, or deny services in a specific case under review. The claims administrator may not charge an injured worker, the injured worker's attorney or the requesting physician for a copy of the relevant portion of the criteria or guidelines used to modify, delay or deny the treatment request.

(4) Nothing in this section precludes authorization of medical treatment not included in the specific criteria under section 9792.8(a)(3).

NOTE

Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 4062, 4600, 4600.4, 4604.5 and 4610, Labor Code.

HISTORY

1. New section filed 12-9-2004 as an emergency; operative 12-13-2004 (Register 2004, No. 50). A Certificate of Compliance must be transmitted to OAL by 4-12-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 4-6-2005 as an emergency; operative 4-12-2005 (Register 2005, No. 14). A Certificate of

Compliance must be transmitted to OAL by 8-10-2005 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 4-6-2005 order, including amendment of section, transmitted to OAL 8-10-2005 and filed 9-22-2005 (Register 2005, No. 38).

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§9792.9. Utilization Review Standards--Timeframe, Procedures and Notice Content

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(a) The request for authorization for a course of treatment as defined in section 9792.6(e) must be in written form.

(1) For purposes of this section, the written request for authorization shall be deemed to have been received by the claims administrator by facsimile on the date the request was received if the receiving facsimile electronically date stamps the transmission. If there is no electronically stamped date recorded, then the date the request was transmitted. A request for authorization transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day as defined in Labor Code section 4600.4 and in section 9 of the Civil Code. The copy of the request for authorization received by a facsimile transmission shall bear a notation of the date, time and place of transmission and the facsimile telephone number to which the request was transmitted or be accompanied by an unsigned copy of the affidavit or certificate of transmission which shall contain the facsimile telephone number to which the request was transmitted. The requesting physician must indicate the need for an expedited review upon submission of the request.

(2) Where the request for authorization is made by mail, and a proof of service by mail exists, the request shall be deemed to have been received by the claims administrator five (5) days after the deposit in the mail at a facility regularly maintained by the United States Postal Service. Where the request for authorization is delivered via certified mail, return receipt mail, the request shall be deemed to have been received by the claims administrator on the receipt date entered on the return receipt. In the absence of a proof of service by mail or a dated return receipt, the request shall be deemed to have been received by the claims administrator on the date stamped as received on the document.

(b) The utilization review process shall meet the following timeframe requirements:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) working days from the date of receipt of the written request for authorization.

(2) If appropriate information which is necessary to render a decision is not provided with the original request for authorization, such information may be requested by a reviewer or non-physician reviewer within five (5) working days from the date of receipt of the written request for authorization to make the proper determination. In no event shall the determination be made more than 14 days from the date of receipt of the original request for authorization by the health care provider.

(A) If the reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request by the requesting physician, a reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.

(3) Decisions to approve a physician's request for authorization prior to, or concurrent with, the provision of medical services to the injured worker shall be communicated to the requesting physician within 24 hours of the decision. Any

decision to approve a request shall be communicated to the requesting physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two business days for prospective review.

(4) Decisions to modify, delay or deny a physician's request for authorization prior to, or concurrent with the provision of medical services to the injured worker shall be communicated to the requesting physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two business days of the decision for prospective review. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

(5) For purposes of this section “normal business day” means a business day as defined in Labor Code section 4600.4 and Civil Code section 9.

(c) When review is retrospective, decisions shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of the medical information that is reasonably necessary to make this determination. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

(d) Failure to obtain prior authorization for emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services, however, may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.

(e) Prospective or concurrent decisions related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must indicate the need for an expedited review upon submission of the request. Decisions related to expedited review refer to the following situations:

(1) When the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or

(2) The normal timeframe for the decision-making process, as described in subdivision (b), would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

(f) The review and decision to deny, delay or modify a request for medical treatment must be conducted by a reviewer, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice.

(g)(1) The timeframe for decisions specified in subdivisions (b)(1), (b)(2) or (c) may only be extended by the claims administrator under the following circumstances:

(A) The claims administrator is not in receipt of all of the necessary medical information reasonably requested.

(B) The reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.

(C) The claims administrator needs a specialized consultation and review of medical information by an expert reviewer.

(2) If subdivisions (A), (B) or (C) above apply, the claims administrator shall immediately notify the requesting

physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the claims administrator cannot make a decision within the required timeframe, and specify the information requested but not received, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. The claims administrator shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered. This notice shall include a statement that if the injured worker believes that a bona fide dispute exists relating to his or her entitlement to medical treatment, the injured worker or the injured worker's attorney may file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, in accordance with sections 10136(b)(1), 10400, and 10408. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision to extend the timeframe and the anticipated date on which the decision will be rendered in accordance with this subdivision. The written notification shall not include the rationale, criteria or guidelines used for the decision.

(3) Upon receipt of information pursuant to subdivisions (A), (B), or (C) above, and (b)(2)(A), the claims administrator shall make the decision to approve, and the reviewer shall make a decision to modify or deny the request for authorization within five (5) working days of receipt of the information for prospective or concurrent review. The decision shall be communicated pursuant to subdivisions (b)(3) or (b)(4).

(4) Upon receipt of information pursuant to subdivisions (A), (B), or (C) above, the claims administrator shall make the decision to approve, and the reviewer shall make a decision to modify or deny the request for authorization within thirty (30) days of receipt of the information for retrospective review.

(h) Every claims administrator shall maintain telephone access from 9:00 AM to 5:30 PM Pacific Time, on normal business days, for health care providers to request authorization for medical services. Every claims administrator shall have a facsimile number available for physicians to request authorization for medical services. Every claims administrator shall maintain a process to receive communications from health care providers requesting authorization for medical services after business hours. For purposes of this section “normal business day” means a business day as defined in Labor Code section 4600.4 and Civil Code section 9. In addition, for purposes of this section the requirement that the claims administrator maintain a process to receive communications from requesting physicians after business hours shall be satisfied by maintaining a voice mail system or a facsimile number for after business hours requests.

(i) A written decision approving a request for treatment authorization under this section shall specify the specific medical treatment service approved.

(j) A written decision modifying, delaying or denying treatment authorization under this section shall be provided to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall contain the following information:

(1) The date on which the decision is made.

(2) A description of the specific course of proposed medical treatment for which authorization was requested.

(3) A specific description of the medical treatment service approved, if any.

(4) A clear and concise explanation of the reasons for the claims administrator's decision.

(5) A description of the medical criteria or guidelines used pursuant to section 9792.8, subdivision (a)(3).

(6) The clinical reasons regarding medical necessity.

(7) A clear statement that any dispute shall be resolved in accordance with the provisions of Labor Code section 4062, and that an objection to the utilization review decision must be communicated by the injured worker or the injured worker's attorney on behalf of the injured worker to the claims administrator in writing within 20 days of receipt of the decision. It shall further state that the 20-day time limit may be extended for good cause or by mutual agreement of the

parties. The letter shall further state that the injured worker may file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with sections 10136(b)(1), 10400, and 10408.

(8) Include the following mandatory language:

Either

“If you want further information, you may contact the local state Information and Assistance office by calling [enter district I & A office telephone number closest to the injured worker] or you may receive recorded information by calling 1-800-736-7401.

or

“If you want further information, you may contact the local state Information and Assistance office closest to you. Please see attached listing (attach a listing of I&A offices and telephone numbers) or you may receive recorded information by calling 1-800-736-7401.”

and

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

In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

(9) Details about the claims administrator's internal utilization review appeals process, if any, and a clear statement that the appeals process is on a voluntary basis, including the following mandatory statement:

“If you disagree with the utilization review decision and wish to dispute it, you must send written notice of your objection to the claims administrator within 20 days of receipt of the utilization review decision in accordance with Labor Code section 4062. You must meet this deadline even if you are participating in the claims administrator's internal utilization review appeals process.”

(k) The written decision modifying, delaying or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the reviewer or expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision shall also disclose the hours of availability of either the review, the expert reviewer or the medical director for the treating physician to discuss the decision which shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time or an agreed upon scheduled time to discuss the decision with the requesting physician. In the vent the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

(l) Authorization may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information from the physician or from the provider of goods or services identified in the request for authorization either by facsimile or mail.

NOTE

Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 4062, 4600, 4600.4, 4604.5 and 4610, Labor Code.

HISTORY

1. New section filed 12-9-2004 as an emergency; operative 12-13-2004 (Register 2004, No. 50). A Certificate of Compliance must be transmitted to OAL by 4-12-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 4-6-2005 as an emergency; operative 4-12-2005 (Register 2005, No. 14). A Certificate of Compliance must be transmitted to OAL by 8-10-2005 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 4-6-2005 order, including amendment of section, transmitted to OAL 8-10-2005 and filed 9-22-2005 (Register 2005, No. 38).

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New query

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§9792.10. Utilization Review Standards--Dispute Resolution

(a)(1) If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code section 4062.

(2) An objection to a decision disapproving in whole or in part a request for authorization of medical treatment, must be communicated to the claims administrator by the injured worker or the injured worker's attorney in writing within 20 days of receipt of the utilization review decision. The 20-day time limit may be extended for good cause or by mutual agreement of the parties.

(3) Nothing in this paragraph precludes the parties from participating in an internal utilization review appeal process on a voluntary basis provided the injured worker and if the injured worker is represented by counsel, the injured worker's attorney have been notified of the 20-day time limit to file an objection to the utilization review decision in accordance with Labor Code section 4062.

(4) Additionally, the injured worker or the injured worker's attorney may file an Application for Adjudication of Claim, and a Request for Expedited Hearing, DWC Form 4, in accordance with sections 10136(b)(1), 10400, and 10408, and request an expedited hearing and decision on his or her entitlement to medical treatment if the request for medical treatment is not authorized within the time limitations set forth in section 9792.9, or when there exists a bona fide dispute as to entitlement to medical treatment.

(b) The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment and to resolve disputes:

(1) In the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

(2) Medical care provided during a concurrent review shall be medical treatment that is reasonably required to cure or relieve from the effects of the industrial injury.

NOTE

Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 4062, 4600, 4600.4, 4604.5 and 4610, Labor Code.

HISTORY

1. New section filed 12-9-2004 as an emergency; operative 12-13-2004 (Register 2004, No. 50). A Certificate of Compliance must be transmitted to OAL by 4-12-2005 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 4-6-2005 as an emergency; operative 4-12-2005 (Register 2005, No. 14). A Certificate of Compliance must be transmitted to OAL by 8-10-2005 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 4-6-2005 order, including amendment of subsection (b)(1), transmitted to OAL 8-10-2005 and filed 9-22-2005 (Register 2005, No. 38).

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New query

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§9792.11. Investigation Procedures: Labor Code s4610 Utilization Review Violations.

(a) To carry out the responsibilities mandated by Labor Code Section 4610(i), the Administrative Director, or his or her designee, shall investigate the utilization review process of any employer, insurer or other entity subject to the provisions of section 4610. The investigation shall include, but not be limited to, review of the practices, files, documents and other records, whether electronic or paper, of the claims administrator, and any other person responsible for utilization review processes for an employer. As used in sections 9792.11 through 9792.15, the phrase 'utilization review organization' includes any person or entity with which the employer, or an insurer, or third party administrator, contracts to fulfill part or all of the employer's utilization review responsibilities under Labor Code section 4610 and Title 8 of the California Code of Regulations, sections 9792.6 through 9792.15.

(b) Notwithstanding Labor Code section 129(a) through (d) and section 129.5 subdivisions (a) through (d), the Administrative Director, or his or her designee, may conduct a utilization review investigation pursuant to Labor Code section 4610, which may include, but is not limited to, an audit of files and other records.

(c) The Administrative Director, or his or her designee, may conduct a utilization review investigation at any location where Labor Code Section 4610 utilization review processes occur, as follows:

(1) For utilization review organizations:

(A) A Routine Investigation shall be initiated at each known utilization review organization at least once every three (3) years. The investigation shall include a review of a random sample of requests for authorization, as defined by section 9792.6(o), received by the utilization review organization during the three most recent full calendar months preceding the date of the issuance of the Notice of Utilization Review Investigation. The investigation may also include a review of any credible complaints received by the Administrative Director since the time of the previous investigation. If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the Administrative Director since the effective date of sections 9792.11 through 9792.15.

(B) Target Investigations:

1. A Return Target Investigation of the same investigation subject shall be conducted within 18 months of the date of the previous investigation if the performance rating was less than eighty-five percent.

2. A Special Target Investigation may be conducted at any time based on credible information indicating the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.

3. The Return Target Investigation and the Special Target Investigation may include: (i) a review of the requests for authorization previously investigated which contained violations; (ii) a review of the file or files pertaining to the complaint or possible violation; (iii) a random sample of requests for authorization received by the utilization review organization during the three most recent full calendar months preceding the date of the issuance of the Notice of Utilization Review Investigation; (iv) a sample of a specific type of request for authorization; and (v) any credible

complaints received by the Administrative Director since the time of any prior investigation. If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the Administrative Director since the effective date of sections 9792.11 through 9792.15.

(2) For a claims administrator:

(A) A Routine Investigation shall be initiated at each claims adjusting location at least once every five (5) years concurrent with the profile audit review done pursuant to Labor Code sections 129 and 129.5. The investigation shall include a review of a random sample of requests for authorization, as defined by section 9792.6(o), received by the claims administrator during the three most recent full calendar months preceding the date of the issuance of the Notice of Utilization Review Investigation. The investigation may also include a review of any credible complaints received by the Administrative Director since the time of the previous investigation. If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the Administrative Director since the effective date of sections 9792.11 through 9792.15.

(B) Target Investigations:

1. A Return Target Investigation of the same investigation subject shall be conducted within 18 months of the date of any previous investigation if the performance rating was less than eighty-five percent.

2. A Special Target Investigation may be conducted at any time based on credible information indicating the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.

3. The Return Target Investigation and the Special Target Investigation may include: (i) a review of the requests for authorization previously investigated which contained violations; (ii) a review of the file or files pertaining to the complaint or possible violation; (iii) a random sample of requests for authorization received by the claims administrator during the three most recent full calendar months preceding the date of the issuance of the Notice of Utilization Review Investigation; (iv) a sample of a specific type of request for authorization; and (v) any credible complaints received by the Administrative Director since the time of any prior investigation. If there has not been a previous investigation, the investigation may include a review of any credible complaints received by the Administrative Director since the effective date of sections 9792.11 through 9792.15.

(d) The number of requests for authorization randomly selected for investigation shall be determined based on the following table:

Population of requests for authorization received during a three month calendar period	Sample Size
5 or less	all
6-10	1 less than total
11-13	2 less than total
14-16	3 less than total
17-18	4 less than total
19-20	5 less than total
21-23	6 less than total
24	17
25-26	18
27-29	19
30-31	20
32-33	21
34-36	22
37-39	23
40-41	24
42-44	25
45-48	26
49-51	27
52-55	28

56-58	29
59-62	30
63-67	31
68-72	32
73-77	33
78-82	34
83-88	35
89-95	36
96-102	37
103-110	38
111-119	39
120-128	40
129-139	41
140-151	42
152-164	43
165-179	44
180-197	45
198-217	46
218-241	47
242-269	48
270-304	49
305-346	50
347-399	51
400-468	52
469-562	53
563-696	54
697-905	55
906-1,272	56
1,273-2,091	57
2,092-5,530	58
5,531 +	59

(e) Complaints concerning utilization review procedures may be submitted with any supporting documentation to the Division of Workers' Compensation using the sample complaint form that is posted on the Division's website at:

http://www.dir.ca.gov/dwc/FORMS/UtilizationReviewcomplaintform.pdf

Complaints should be mailed to DWC Medical Unit-UR, P.O. Box 71010, Oakland, CA 94612, attention UR Complaints or emailed to DWCManagedCare@dir.ca.gov. Complaints received by the Division of Workers' Compensation will be reviewed and investigated, if necessary, to determine if the complaints are credible and indicate the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.

(f) Administrative penalties may be assessed for any failure to comply with Labor Code section 4610, or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations, except that the penalties listed in section 9792.12(a)(6) through (14) and (b) shall only be imposed if the request was subject to the Labor Code section 4610 utilization review process.

(g) In the event an investigation of utilization review processes is done at the claims administrator's adjusting location, concurrent with a profile audit review done pursuant to Labor Code section 129 or 129.5, the administrative penalty amounts for each violation of Labor Code section 4610 or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations, shall be governed by sections 9792.11 through 9792.15. Any such administrative penalty for utilization review process violations shall apply in lieu of the administrative penalty amount allowed under the audit regulations at section 10111.2(b)(8)[vi] of Title 8, California Code of Regulations. In addition, any report of findings from the investigation and any Order to Show Cause re: Assessment of Administrative Penalties prepared by the Administrative Director, or his or her designee, based on violations of Labor Code section 4610 or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations, shall be prepared separately from any audit report or assessment of administrative penalties made pursuant to Labor Code section 129 and 129.5. The Order to Show Cause re: Assessment of Administrative Penalties for violations of sections 9792.6 et seq of Title 8 of the California Code of Regulations shall be governed by sections 9792.11 through 9792.15.

(h) The Administrative Director, or his or her designee, may also utilize the provisions of Government Code sections

11180 through 11191 to determine whether any violations of the requirements in Labor Code section 4610 or sections 9792.6 through 9792.12 of Title 8, California Code of Regulations, have occurred.

(i) Sections 9792.11 through 9792.15 of Title 8 of the California Code of Regulations shall apply to any Labor Code section 4610 utilization review investigation conducted on or after the effective date of sections 9792.11 through 9792.15 and for conduct which occurred on or after the effective date of sections 9792.11 through 9792.15.

(j) Unless the Administrative Director in his or her discretion determines that advance notice will render a Special Target or Return Target Investigation less useful, the claims administrator or utilization review organization shall be notified of its selection for an Investigation. Claims administrators and utilization review organizations shall be sent a Notice of Utilization Review Investigation. The Notice of Utilization Review Investigation shall require the investigation subject to provide the following:

(1) A description of the system used to identify each request for authorization (if applicable). To the extent the system identifies any of the following information in an electronic format, the claims administrator or utilization review organization shall provide in an electronic format a list of each and every request for authorization received at the investigation site during a three month calendar period specified by the Administrative Director, or his or her designee, and the following data elements: i) a unique identifying number for each request for authorization if one has been assigned; ii) the name of the injured worker; iii) the claim number used by the claims adjuster; iv) the initial date of receipt of the request for authorization; v) the type of review (expedited prospective, prospective, expedited concurrent, concurrent, retrospective, appeal); vi) the disposition (approve, deny, delay, modify, withdrawal); and, vii) if applicable, the type of person who withdrew the request (requesting physician, claims adjuster, injured employee or his or her attorney, or other person). In the event the claims administrator or utilization review organization is not able to provide the list in an electronic format, the list shall be provided in such a form that the listed requests for authorization are sorted in the following order: by type of utilization review, type of disposition, and date of receipt of the initial request;

(2) A description of all media used to transmit, share, record or store information received and transmitted in reference to each request, whether printed copy, electronic, fax, diskette, computer drive or other media;

(3) A legend of any and all numbers, letters and other symbols used to identify the disposition (e.g. approve, deny, modify, delay or withdraw), type of review (expedited prospective, prospective, expedited concurrent, concurrent, retrospective, appeal), and other abbreviations used to document individual requests for authorization and a data dictionary for all data elements provided;

(4) A description of the methods by which the medical director for utilization review ensures that the process by which requests for authorization are reviewed and approved, modified, delayed, or denied is in compliance with Labor Code section 4610 and sections 9792.6 through 9792.10, as required by sections 9792.6(l) and 9792.7(b) of Title 8 of the California Code of Regulations; and

(5) The following additional information, may be requested by the Administrative Director or his or her designee, as applicable to the type of entity investigated: i) whether utilization review services are provided externally; ii) the name(s) of the utilization review organization(s); iii) the name and address of the employer; and iv) the name and address of the insurer.

(k) The utilization review organization or claims administrator shall provide the requested information listed in subdivision (j) within fourteen (14) calendar days of receipt of the Notice of Utilization Review Investigation. Based on the information provided, the Administrative Director, or his or her designee, shall provide the claims administrator or utilization review organization with a Notice of Investigation Commencement, which shall include a list of randomly selected requests for authorization from a three month calendar period designated by the Administrative Director and complaint files (if applicable) for investigation.

(l) For utilization review organizations: Within fourteen (14) calendar days of receipt from the Administrative Director, or his or her designee, of the Notice of Investigation Commencement, the utilization review organization shall deliver to the Administrative Director, or his or her designee, a true and complete copy of all records, whether

electronic or paper, for each request for authorization listed. Copies of the records shall be delivered with a statement signed under penalty of perjury by the custodian of records for the location at which the records are held, attesting that all of the records produced are true, correct and complete copies of the originals, in his or her possession. After reviewing the records, the Administrative Director, or his or her designee, shall determine if an onsite investigation is required. If an onsite investigation is required, fourteen (14) calendar days notice shall be provided to the utilization review organization.

(m) For claims administrators: The Notice of Investigation Commencement shall be provided to the claims administrator at least fourteen (14) calendar days prior to the commencement of the onsite investigation. The claims administrator shall produce for the Administrative Director, or his or her designee, on the first day of commencement of the onsite investigation, the true, correct and complete copies, whether electronic or paper, whether located onsite or offsite, of each request for authorization identified by the Administrative Director or his or her designee, together with a statement signed under penalty of perjury by the custodian of records for the location at which the records are held, attesting that all of the records produced are true, correct and complete copies of the originals.

(n) In the event the Administrative Director, or his or her designee, determines additional records or files are needed for review during the course of an onsite investigation, the claims administrator or utilization review organization shall produce the requested records in the manner described by subdivision 9792.11(k), within one (1) working day when the records are located at the site of investigation, and within five (5) working days when the records are located at any other site. Any such request by the Administrative Director or his or her designee also may include records or files pertaining to any complaint alleging violations of Labor Code sections 4610 or sections 9792.6 through 9792.12 of Title 8 of the California Code of Regulations. The Administrative Director or his or her designee may extend the time for production of the requested records for good cause.

(o) If the date or deadline in sections 9792.9(b) and 9792.9(c) of Title 8 of the California Code of Regulations to perform any act related to utilization review practices falls on a weekend or holiday, for the purposes of assessing penalties, the act may be performed on the next normal business day, as defined by Labor Code section 4600.4 and Civil Code section 9. This subdivision shall not apply in cases involving concurrent or expedited review. The timelines in sections 9792.9(b) of Title 8 of the California Code of Regulations shall only be extended as provided under section 9792.9(g) of that title.

(p) If the claims administrator or utilization review organization does not record the date a document is received, it shall be deemed received by using the method set out in section 9792.9(a)(2), except that:

(1) where the request for authorization is made by mail through the U.S. postal service and no proof of service by mail exists, the request shall be deemed to have been received by the claims administrator, or utilization review organization on whichever date is earlier, either the receipt date stamped by the addressee or within five (5) calendar days of the date stated in the request for authorization or where the addressee can show a delay in mailing by the postmark date on the mailing envelope then: (A) within five (5) calendar days of the postmark date, if the place of mailing and place of address are both within California; (B) within ten (10) calendar days if the place of address is within the United States but outside of California; or (C) within twenty (20) calendar days if the place of address is outside of the United States; and

(2) where the request for authorization is made by express mail, overnight mail or courier without any proof of service, the request shall be deemed received by the addressee on the date specified in any written confirmation of delivery.

(q) Upon initiating a Special Target Investigation, the Administrative Director, or his or her designee, shall provide to the claims administrator or the utilization review organization a written description of the factual information or of the complaint containing factual information or a copy of the complaint that triggered the utilization review investigation, unless the Administrative Director or his or her designee determines that providing the information would make the investigation less useful. The claims administrator or utilization review organization shall have ten (10) business days upon receipt of the written description or copy of the complaint to provide a written response to the Administrative Director or his or her designee. After reviewing the written response, the Administrative Director, or his or her designee, shall either close the investigation without the assessment of administrative penalties or conduct further

investigation to determine whether a violation exists and whether to impose penalty assessments.

(r) For utilization review organizations: The files and other records, whether electronic or paper, that pertain to the utilization review process shall be retained for at least three (3) years following either: (1) the most recent utilization review decision for each injured employee, or (2) the date on which any appeal from the assessment of penalties for violations of Labor Code section 4610 or sections 9792.6 through 9792.12 is final, whichever date is later. Claims administrators shall retain their claim files as set forth in section 10102 of Title 8 of the California Code of Regulations.

(s) Upon receipt of a notice of Routine or Target Investigation or any other request from the Administrative Director, or his or her designee, to review all files and other records pertaining to the employer's utilization review process, whether electronic or paper, that are created or held outside of California, the claims administrator or utilization review organization shall either deliver all such requested files and other records to an address in California specified by the Administrative Director, or his or her designee, or reimburse the Administrative Director for the actual expenses of each investigator who travels outside of California to the place where the records are held, including the per diem expenses, travel expenses and compensated overtime of the investigators.

(t) A preliminary investigation report will be provided to the claims administrator or utilization review organization. The preliminary investigation report shall consist of the preliminary notice of utilization review penalty assessments, the performance rating, and may include one or more requests for additional documentation or compliance. A conference to discuss the preliminary investigation report shall be scheduled, if necessary, within twenty-one calendar days from the issuance of the preliminary findings. Following the conference, the Administrative Director or his or her designee shall issue an Order to Show Cause Re: Assessment of Administrative Penalty (which shall include the final investigation report), as set forth in section 9792.15.

(u) The claims administrator or utilization review organization may stipulate to the allegations and final report set forth in the Order to Show Cause.

(v) Within forty-five (45) calendar days of the service of the Order to Show Cause Re: Assessment of Administrative Penalties, if no answer has been filed, or within 15 calendar days after any and all appeals have become final, the claims administrator or utilization review organization shall provide the following:

(1) A notice, which shall include a copy of the final investigation report, the measures actually implemented to abate such conditions, and the website address for the Division where the performance rating and summary of violations is posted. If a hearing was conducted under section 9792.15, the notice shall include the Final Determination in lieu of the final investigation report.

(2) For utilization review organizations: the notice must be served on any employer or third party claims administrator that contracted with the utilization review organization and whose utilization review process was assessed with a penalty pursuant to section 9792.12, and any insurer whose utilization review process was assessed with a penalty pursuant to section 9792.12.

(3) For claims administrators: the notice must be served on any self-insured employer and any insurer whose utilization review process was assessed with a penalty pursuant to section 9792.12.

(4) The notice shall be served by certified mail.

(5) Documentation of compliance with this section shall be served on the Administrative Director within thirty calendar days from the date the notice was served.

Note: Authority cited: Sections 11180-11191, Government Code; and Sections 133, 4610 and 5307.3, Labor Code. Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610 and 4614, Labor Code.

HISTORY

1. New section filed 6-7-2007; operative 6-7-2007 pursuant to GovernmentCode section 11343.4 (Register 2007, No. 23). For prior history, see Register 2005, No. 38

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New query

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§9792.12. Administrative Penalty Schedule for Labor Code s4610 Utilization Review Violations.

(a) Mandatory Administrative Penalties. Notwithstanding Labor Code section 129.5(c)(1) through (c)(3), the penalty amount that shall be assessed for each failure to comply with the utilization review process required by Labor Code section 4610 and sections 9792.6 through 9792.12 of Title 8 of the California Code of Regulations, is:

(1) For failure to establish a Labor Code section 4610 utilization review plan: $50,000;

(2) For failure to include all of the requirements of section 9792.7(a) in the utilization review plan: $5,000;

(3) For failure to file the utilization review plan or a letter in lieu of a utilization review plan with the Administrative Director as required by section 9792.7(c): $10,000;

(4) For failure to file a modified utilization review plan with the Administrative Director within 30 calendar days after the claims administrator makes a material modification to the plan as required by section 9792.7(c): $5,000;

(5) For failure to employ or designate a physician as a medical director, as defined in section 9792.6(l), of the utilization review process, as required by section 9792.7(b): $50,000;

(6) For issuance of a decision to modify or deny a request for authorization regarding a medical treatment, procedure, service or product where the requested treatment, procedure or service is not within the reviewer's scope of practice (as set forth by the reviewer's licensing board): $25,000;

(7) For failure to comply with the requirement that only a licensed physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve, except as provided for in Labor Code section 4604.5(d) and section 9792.9(b)(2) and (3): $25,000;

(8) For failure of a non-physician reviewer (person other than a reviewer, expert reviewer or medical director as defined in section 9792.6 of Title 8 of the California Code of Regulations), who approves an amended request to possess an amended written request for treatment authorization as provided under section 9792.7(b)(3) when a physician has voluntarily withdrawn a request in order to submit an amended request: $1,000;

(9) For failure to communicate the decision in response to a request for an expedited review, as defined in section 9792.6(g), in a timely fashion, as required by section 9792.9: $15,000;

(10) For failure to approve the request for authorization solely on the basis that the condition for which treatment was requested is not addressed by the medical treatment utilization schedule adopted pursuant to section 5307.27 of the Labor Code: $5,000;

(11) For failure to discuss or document attempts to discuss reasonable options for a care plan with the requesting physician as required by Labor Code section 4610(g)(3)(B), prior to denying authorization of or discontinuing medical

care, in the case of concurrent review: $10,000;

(12) For failure to respond to the request for authorization by the injured employee's requesting treating physician, in the case of a non-expedited concurrent review: $2,000;

(13) For failure to respond to the request for authorization by the injured employee's requesting treating physician, in the case of a non-expedited prospective review: $1,000;

(14) For failure to respond to the request for authorization by the injured employee's requesting treating physician, in the case of a retrospective review: $500;

(15) For failure to disclose or otherwise to make available, if requested, the Utilization Review criteria or guidelines to the public, as required by Labor Code section 4610, subdivision (f)(5) and section 9792.7(d) of Title 8 of the California Code of Regulations: $100.

(16) For failure to timely serve the Administrative Director with documentation of compliance pursuant to section 9792.11(v)(5): $500.

(17) For failure to timely comply with any compliance requirement listed in the Final Report if no timely answer was filed or any compliance requirement listed in the Determination and Order after any and all appeals have become final: $500.

(b) Additional Penalties and Remediation.

(1) After conducting a Routine or Return Target Investigation, the Administrative Director, or his or her designee, shall calculate the investigation subject's performance rating based on its review of the randomly selected requests. The investigation subject's performance rating may also be calculated after conducting a Special Target Investigation. The performance rating will be calculated as follows:

(A) The factor for failure to make and/or provide a timely response to a request for authorization shall be determined by dividing the number of randomly selected requests with violations involving failure to make or provide a timely response to a request for authorization by the total number of randomly selected requests.

(B) The factor for notice(s) with faulty content shall be determined by dividing the number of requests involving notice(s) with faulty content by the total number of randomly selected requests.

(C) The factor for failure to issue notice(s) to all appropriate parties shall be determined by the number of requests involving the failure to issue notice(s) to all appropriate parties by the total number of randomly selected requests.

(D) The investigation subject's investigation performance rating will be determined by adding the factors calculated pursuant to subsections (b)(1)(A) through (b)(1)(C), dividing the total by three, subtracting from one, and multiplying by one-hundred.

(E) If the investigation subject's performance rating meets or exceeds eighty-five percent, the Administrative Director, or his or her designee, shall assess no penalties for the violations listed in this subdivision. If the performance rating is less than eighty-five percent, the violations shall be assessed as set forth below in (b)(2) through (b)(5):

(2) For the types of violations listed below in (b)(4) and (b)(5), each violation shall have a penalty amount, as specified of $100 in (b)(4) or $50 in (b)(5). The penalty amount specified in (b)(4) and (b)(5) shall be waived if the investigation subject's performance rating meets or exceeds eighty-five percent, or if following a Routine Investigation the claims administrator or utilization review organization agrees in writing to:

(A) Deliver to the Administrative Director, or his or her designee, within no more than thirty (30) calendar days from the date of the agreement or the number of days otherwise specified, written evidence, tendered with a declaration made under penalty of perjury, that explains or demonstrates how the violation has been abated in compliance with the

applicable statute or regulations and the terms of abatement specified by the Administrative Director; and

(B) Grant the Administrative Director, or his or her designee, entry, upon request and within the time frame specified in the agreement, to the site at which the violation was found for a Return Target Investigation for the purpose of verifying compliance with the abatement measures reported in subdivision 9792.12(b)(1)(A) above and agree to a review of randomly selected requests for authorization; and

(C) Reinstatement of the penalty amount previously waived for each such instance, in the event the violative condition is not abated within the time period specified by the Administrative Director, or his or her designee, or in the event that such abatement measures are not consistent with abatement terms specified by the Administrative Director, or his or her designee.

(3) In the event the Administrative Director, or his or her designee, returns for a Return Target Investigation, after the initial violation has become final, and the subject fails to meet the performance standard of 85%, the amount of penalty shall be calculated as described below and in no event shall the penalty amount be waived:

(A) The penalty amount for each violation shall be multiplied by two for a second investigation, but in no event shall the total penalties for the violations exceed $100,000;

(B) The penalty amount for each violation shall be multiplied by five for a third investigation, but in no event shall the total penalties for the violations exceed $200,000;

(C) The penalty amount for each violation shall be multiplied by ten for a fourth investigation, but in no event shall the total penalties for the violations exceed $400,000.

(4) For each of the violations listed below, the penalty amount shall be $100.00 for each instance found by the Administrative Director, or his or her designee:

(A) For failure to immediately notify all parties in the manner described in section 9792.9(g)(2) of the basis for extending the decision date for a request for medical treatment;

(B) For failure to document efforts to obtain information from the requesting party prior to issuing a denial of a request for authorization on the basis of lack of reasonable and necessary information;

(C) For failure to make a decision to approve or modify or deny the request for authorization, within five (5) working days of receipt of the requested information for prospective or concurrent review, and to communicate the decision as required by section 9792.9(g)(3);

(D) For failure to make and communicate a retrospective decision to approve, modify, or deny the request, within thirty (30) working days of receipt of the information, as required by section 9792.9(g)(4);

(E) For failure to include in the written decision that modifies, delays or denies authorization, all of the items required by section 9792.9(j);

(F) For failure to disclose or otherwise to make available, if requested, the Utilization Review criteria or guidelines, to the injured employee whose case is under review, as required by Labor Code section 4610(f)(5) and section 9792.8(a)(3) Title 8 of the California Code of Regulations.

(5) For each of the violations listed below, the penalty amount shall be $50.00 for each instance found by the Administrative Director, or his or her designee:

(A) For failure by a non-physician or physician reviewer to timely notify the requesting physician, as required by section 9792.9(b)(2), that additional information is needed in order to make a decision in compliance with the timeframes contained in section 9792.9(b);

(B) For failure to communicate the decision to approve to the requesting physician in the case of prospective or concurrent review, by phone or fax within 24 hours of the decision, as required by Labor Code section 4610(g)(3)(A) and in accordance with section 9792.9(b)(3) of Title 8 of the California Code of Regulations;

(C) For failure to send a written notice of the decision to modify, delay or deny to the requesting party, and to the injured employee and to his or her attorney if any, within twenty four (24) hours of making the decision for concurrent review, or within two business days for prospective review, as required by Labor Code section 4610(g)(3)(A) and section 9792.9(b)(4) of Title 8 of the California Code of Regulations;

(D) For failure to communicate a decision in the case of retrospective review as required by section 9792.9(c) within thirty (30) days of receipt of the medical information that was reasonably necessary to make the determination;

(E) For failure to provide immediately a written notice to the requesting party that a decision on the request for authorization cannot be made within fourteen (14) days for prospective and concurrent reviews, or within thirty (30) days for retrospective in accordance with section 9792.9(g)(2);

(F) For failure to document that one of the following events occurred prior to the claims administrator providing written notice for delay under Labor Code section 4610(g)(5):

(1) the claims administrator had not received all of the information reasonably necessary and requested;

(2) the employer or claims administrator has requested a consultation by an expert reviewer;

(3) the physician reviewer has requested an additional examination or test be performed;

(G) For failure to explain in writing the reason for delay as required by section 9792.9(g)(2) of Title 8 of the California Code of Regulations when the decision to delay was made under one of the circumstances listed in section 9792.9(g)(1).

(6) After the time to file an answer to the Order to Show Cause Re: Assessment of Administrative Penalties has elapsed and no answer has been filed or after any and all appeals have become final, the Administrative Director, or his or her designee, shall post on the website for the Division of Workers' Compensation the performance rating and summary of violations for each utilization review investigation.

(c) The penalty amounts specified for violations under subsection 9792.12(a) and (b) above may, in the discretion of the Administrative Director, be reduced after consideration of the factors set out in section 9792.13 of Title 8 of the California Code of Regulations. Failure to abate a violation found under section 9792.12(b)(4) and (b)(5), in the time period or in a manner consistent with that specified by the Administrative Director, or his or her designee, shall result in the assessment of the full original penalty amount proposed by the Administrative Director for that violation.

Note: Authority cited: Sections 133, 4610 and 5307.3, Labor Code. Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610 and 4614, Labor Code.

HISTORY

1. New section filed 6-7-2007; operative 6-7-2007 pursuant to GovernmentCode section 11343.4 (Register 2007, No. 23).

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Subchapter 1. Administrative Director--Administrative Rules
Article 5.5.1. Utilization Review Standards

New query

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§9792.13. Assessment of Administrative Penalties - Penalty Adjustment Factors.

(a) In any investigation that the Administrative Director deems appropriate, the Administrative Director, or his or her designee, may mitigate a penalty amount imposed under section 9792.12 after considering each of these factors:

(1) The medical consequences or gravity of the violation(s);

(2) The good faith of the claims administrator or utilization review organization. Mitigation for good faith shall be determined based on documentation of attempts to comply with the Labor Code and regulations and shall result in a reduction of 20% for each applicable penalty;

(3) The history of previous penalties;

(4) The frequency of violations found during the investigation giving rise to a penalty;

(5) Penalties may be mitigated outside the above mitigation guidelines in extraordinary circumstances, when strict application of the mitigation guidelines would be clearly inequitable; and

(6) In the event an objection or appeal is filed pursuant to subsection 9792.15 of these regulations, whether the claims administrator or utilization review organization abated the alleged violation within the time period specified by the Administrative Director or his or her designee.

(b) The Administrative Director, or his or her designee, may assess both an administrative penalty under Labor Code section 4610 and a civil penalty under subdivision (e) of Labor Code section 129.5 based on the same violation(s).

(c) The Administrative Director, or his or her designee, shall not collect payment for an administrative penalty under Labor Code section 4610 from both the utilization review organization and the claims administrator for an assessment based on the same violation(s).

(d) Where an injured worker's or a requesting provider's refusal to cooperate in the utilization review process has prevented the claims administrator or utilization review organization from determining whether there is a legal obligation to perform an act, the Administrative Director, or his or her designee, may forego a penalty assessment for any related act or omission. The claims administrator or utilization review organization shall have the burden of proof in establishing both the refusal to cooperate and that such refusal prevented compliance with the relevant applicable statute or regulation.

Note: Authority cited: Sections 133, 4610 and 5307.3, Labor Code. Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610 and 4614, Labor Code.

HISTORY

1. New section filed 6-7-2007; operative 6-7-2007 pursuant to GovernmentCode section 11343.4 (Register 2007, No. 23).

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New query

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§9792.14. Liability for Penalty Assessments.

(a) If more than one claims administrator or utilization review organization has been responsible for a claim file, utilization review file or other file that is being investigated, penalties may be assessed against each such entity for the violation(s) that occurred during the time each such entity had responsibility for the file or for the utilization review process.

(b) The claims administrator or utilization review organization is liable for all penalty assessments made against it, except that if the subject of the investigation is acting as an agent, the agent and the principal are jointly and severally liable for all penalty assessments resulting from a given investigation. This paragraph does not prohibit an agent and its principal from allocating the administrative penalty liability between them. Liability for civil penalties assessed pursuant to Labor Code section 129.5(e) for violations under Labor Code section 4610 or sections 9792.6 through 9792.10 of Title 8 of the California Code of Regulations shall not be allocated.

(c) Successor liability may be imposed on a claims administrator or utilization review organization that has merged with, consolidated, or otherwise continued the business of a corporation, other business entity or other person that was cited by the Administrative Director for violations of Labor Code section 4610 or sections 9792.6 through 9792.12. The surviving entity or person responsible for administering the utilization review process for an employer, shall assume and be liable for all the liabilities, obligations and penalties of the prior corporation or business entity. Successor liability will be imposed if there has been a substantial continuity of business operations and/or the new business uses the same or substantially the same work force.

Note: Authority: Sections 133, 4610 and 5307.3, Labor Code. Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610 and 4614, Labor Code.

HISTORY

1. New section filed 6-7-2007; operative 6-7-2007 pursuant to GovernmentCode section 11343.4 (Register 2007, No. 23).

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New query

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§9792.15. Administrative Penalties Pursuant to Labor Code s4610 - Order to Show Cause, Notice of Hearing, Determination and Order, and Review Procedure.

(a) Pursuant to Labor Code section 4610(i), the Administrative Director shall issue an Order to Show Cause Re: Assessment of Administrative Penalty when the Administrative Director, or his or her designee (the investigating unit of the Division of Workers' Compensation), has reason to believe that an employer, insurer or other entity subject to Labor Code section 4610 has failed to meet any of the requirements of this section or of any regulation adopted by the Administrative Director pursuant to the authority of section 4610.

(b) The order shall be in writing and shall include all of the following:

(1) Notice that an administrative penalty may be assessed;

(2) The final investigation report, which shall consist of the notice of utilization review penalty assessment, the performance rating, and may include one or more requests for documentation or compliance;

(c) The order shall be served personally or by registered or certified mail.

(d) Within thirty (30) calendar days after the date of service of the Order to Show Cause Re: Assessment of Administrative Penalties, the claims administrator or utilization review organization may pay the assessed administrative penalties or file an answer as the respondent with the Administrative Director, in which the respondent may:

(1) Admit or deny in whole or in part any of the allegations set forth in the Order to Show Cause;

(2) Contest the amount of any or all proposed administrative penalties;

(3) Contest the existence of any or all of the violations;

(4) Set forth any affirmative and other defenses;

(5) Set forth the legal and factual bases for each defense.

(e) Any allegation and proposed penalty stated in the Order to Show Cause that is not contested shall be paid within thirty (30) calendar days after the date of service of the Order to Show Cause.

(f) Failure to timely file an answer shall constitute a waiver of the respondent's right to an evidentiary hearing. Unless set forth in the answer, all defenses to the Order to Show Cause shall be deemed waived. If the answer is not timely filed, within ten (10) days of the date for filing the answer, the respondent may file a written request for leave to file an answer. The respondent may also file a written request for leave to assert additional defenses, which the Administrative Director may grant upon a showing of good cause.

(g) The answer shall be in writing and signed by, or on behalf of, the claims administrator or utilization review organization and shall state the respondent's mailing address. It need not be verified or follow any particular form.

(1) The respondent must file the original and one copy of the answer on the Administrative Director and concurrently serve one copy of the answer on the investigating unit of the Division of Workers' Compensation (designated by the Administrative Director). The original and all copies of any filings required by this section shall have a proof of service attached.

(h) Within sixty (60) calendar days of the issuance of the Order to Show Cause Re: Assessment of Administrative Penalty, the Administrative Director shall issue the Notice of the date, time and place of a hearing. The date of the hearing shall be at least ninety calendar days from the date of service of the Notice. The Notice shall be served personally or by registered or certified mail. Continuances will not be allowed without a showing of good cause.

(i) At any time before the hearing, the Administrative Director may file or permit the filing of an amended complaint or supplemental Order to Show Cause. All parties shall be notified thereof. If the amended complaint or supplemental Order to Show Cause presents new charges, the Administrative Director shall afford the respondent a reasonable opportunity to prepare its defense, and the respondent shall be entitled to file an amended answer.

(j) At the Administrative Director's discretion, the Administrative Director may proceed with an informal pre-hearing conference with the respondent in an effort to resolve the contested matters. If any or all of the violations or proposed penalties in the Order to Show Cause, the amended Order or the supplemental Order remain contested, those contested matters shall proceed to an evidentiary hearing.

(k) Whenever the Administrative Director's Order to Show Cause has been contested, the Administrative Director may designate a hearing officer to preside over the hearing. The authority of the Administrative Director or the designated hearing officer shall include, but is not limited to: conducting a pre-hearing settlement conference; setting the date for an evidentiary hearing and any continuances; issuing subpoenas for the attendance of any person residing anywhere within the state as a witness or party at any pre-hearing conference and hearing; issuing subpoenas duces tecum for the production of documents and things at the hearing; presiding at the hearings; administering oaths or affirmations and certifying official acts; ruling on objections and motions; issuing pre-hearing orders; and preparing a Recommended Determination and Opinion based on the hearing.

(l) The Administrative Director or the designated hearing officer shall set the time and place for any pre-hearing conference on the contested matters in the Order to Show Cause, and shall give sixty (60) calendar days written notice to all parties.

(m) The pre-hearing conference may address one or more of the following matters:

(1) Exploration of settlement possibilities;

(2) Preparation of stipulations;

(3) Clarification of issues;

(4) Rulings on the identity of witnesses and limitation of the number of witnesses;

(5) Objections to proffers of evidence;

(6) Order of presentation of evidence and cross-examination;

(7) Rulings regarding issuance of subpoenas and protective orders;

(8) Schedules for the submission of written briefs and schedules for the commencement and conduct of the hearing;

(9) Any other matters as shall promote the orderly and prompt conduct of the hearing.

(n) The Administrative Director or the designated hearing officer shall issue a pre-hearing order incorporating the matters determined at the pre-hearing conference. The Administrative Director or the designated hearing officer may direct one or more of the parties to prepare the pre-hearing order.

(o) Not less than thirty (30) calendar days prior to the date of the evidentiary hearing, the respondent shall file and serve the original and one copy of a written statement with the Administrative Director or the designated hearing officer specifying the legal and factual bases for its answer and each defense, listing all witnesses the respondent intends to call to testify at the hearing, and appending copies of all documents and other evidence the respondent intends to introduce into evidence at the hearing. A copy of the written statement and its attachments shall also concurrently be served on the investigating unit of the Division of Workers' Compensation. If the written statement and supporting evidence are not timely filed and served, the Administrative Director or the designated hearing officer shall dismiss the answer and issue a written Determination based on the evidence provided by the investigating unit of the Division of Workers' Compensation. Within ten (10) calendar days of the date for filing the written statement and supporting evidence, the respondent may file a written request for leave to file a written statement and supporting evidence. The Administrative Director or the designated hearing officer may grant the request, upon a showing of good cause. If leave is granted, the written statement and supporting evidence must be filed and served no later than ten (10) calendar days prior to the date of the hearing.

(p) Oral testimony shall be taken only on oath or affirmation.

(q)(1) Each party shall have these rights: to call and examine witnesses, to introduce exhibits; to cross-examine opposing witnesses on any matter relevant to the issues even though that matter was not covered in the direct examination; to impeach any witness regardless of which party first called him or her to testify; and to rebut the evidence.

(2) In the absence of a contrary order by the Administrative Director or the designated hearing officer, the investigating unit of the Division of Workers' Compensation shall present evidence first.

(3) The hearing need not be conducted according to the technical rules relating to evidence and witnesses, except as hereinafter provided. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make the admission of the evidence improper over objection in civil actions.

(4) Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but upon timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions. An objection is timely if made before submission of the case to the Administrative Director or to the designated hearing officer.

(r) The written affidavit or declaration of any witness may be offered and shall be received into evidence provided that (i) the witness was listed in the written statement pursuant to section 9792.15(n); (ii) the statement is made by affidavit or by declaration under penalty of perjury; (iii) copies of the statement have been delivered to all opposing parties at least twenty (20) days prior to the hearing; and (iv) no opposing party has, at least ten (10) days before the hearing, delivered to the proponent of the evidence a written demand that the witness be produced in person to testify at the hearing. The Administrative Director or the designated hearing officer shall disregard any portion of the statement received pursuant to this regulation that would be inadmissible if the witness were testifying in person, but the inclusion of inadmissible matter does not render the entire statement inadmissible. Upon timely demand for production of a witness in lieu of admission of an affidavit or declaration, the proponent of that witness shall ensure the witness appears at the scheduled hearing and the proffered declaration or affidavit from that witness shall not be admitted. If the Administrative Director or the designated hearing officer determines that good cause exists that prevents the witness from appearing at the hearing, the declaration may be introduced in evidence, but it shall be given only the same effect as other hearsay evidence.

(s) The Administrative Director or the designated hearing officer shall issue a written Determination and Order Assessing Penalty, if any, including a statement of the basis for the Determination and each penalty assessed, within

sixty (60) days of the date the case was submitted for decision, which shall be served on all parties. This requirement is directory and not jurisdictional.

(t) The Administrative Director shall have sixty (60) calendar days to adopt or modify the Determination and Order Assessing Penalty issued by the Administrative Director or the designated hearing officer. In the event the recommended Determination and Order of the designated hearing officer is modified, the Administrative Director shall include a statement of the basis for the Determination and Order Assessing Penalty signed and served by the Administrative Director, or his or her designee. If the Administrative Director does not act within sixty (60) calendar days, then the recommended Determination and Order shall become the Determination and Order on the sixty-first calendar day.

(u) The Determination and Order Assessing Penalty shall be served on all parties personally or by registered or certified mail by the Administrative Director.

(v) The Determination and Order Assessing Penalty, if any, shall become final on the day it is served, unless the aggrieved party files a timely Petition Appealing the Determination of the Administrative Director. All findings and assessments in the Determination and Order Assessing Penalty not contested in the Petition Appealing the Determination of the Administrative Director shall become final as though no petition were filed.

(w) At any time prior to the date the Determination and Order Assessing Penalty becomes final, the Administrative Director or designated hearing officer may correct the Determination and Order Assessing Penalty for clerical, mathematical or procedural error(s).

(x) Penalties assessed in a Determination and Order Assessing Penalty shall be paid within thirty (30) calendar days of the date the Determination and Order became final. A timely filed Petition Appealing the Determination of the Administrative Director shall toll the period for paying the penalty assessed for the item appealed.

(y) All appeals from any part or the entire Determination and Order Assessing Penalty shall be made in the form of a Petition Appealing the Determination of the Administrative Director, in conformance with the requirements of chapter 7, part 4 of Division 4 of the Labor Code. Any such Petition Appealing the Determination of the Administrative Director shall be filed at the Appeals Board in San Francisco (and not with any district office of the Workers' Compensation Appeals Board), in the same manner specified for petitions for reconsideration.

Note: Authority cited: Sections 133, 4610 and 5307.3, Labor Code. Reference: Sections 129, 129.5, 4062, 4600, 4600.4, 4604.5, 4610, 4614 and 5300, Labor Code.

HISTORY

1. New section filed 6-7-2007; operative 6-7-2007 pursuant to GovernmentCode section 11343.4 (Register 2007, No. 23).

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Subchapter 1. Administrative Director--Administrative Rules
Article 5.5.2. Medical treatment utilization schedule

New query

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§9792.20 Medical Treatment Utilization Schedule -Definitions

As used in this Article:

(a) "American College of Occupational and Environmental Medicine (ACOEM)" is a medical society of physicians and other health care professionals specializing in the field of occupational and environmental medicine, dedicated to promoting the health of workers through preventive medicine, clinical care, research, and education.

(b) "ACOEM Practice Guidelines" means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, 2nd Edition (2004). A copy may be obtained from the American College of Occupational and Environmental Medicine, 25 Northwest Point Blvd., Suite 700, Elk Grove Village, Illinois, 60007-1030 (www.acoem.org).

(c) "Chronic pain" means any pain that persists beyond the anticipated time of healing.

(d) "Claims administrator" is a self-administered workers' compensation insurer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator, or the California Insurance Guarantee Association.

(e) "Evidence-based " means based, at a minimum, on a systematic review of literature published in medical journals included in MEDLINE.

(f) "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment.

(g) "Medical treatment" is care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.26.

(h) "Medical treatment guidelines" means the most current version of written recommendations revised within the last five years which are systematically developed by a multidisciplinary process through a comprehensive literature search to assist in decision-making about the appropriate medical treatment for specific clinical circumstances.

(i) "MEDLINE" is the largest component of PubMed, the U.S. National Library of Medicine's database of biomedical citations and abstracts that is searchable on the Web. Its website address is www.pubmed.gov.

(j) "Nationally recognized" means published in a peer-reviewed medical journal; or developed, endorsed and disseminated by a national organization with affiliates based in two or more U.S. states; or currently adopted for use by one or more U.S. state governments or by the U.S. federal government; and is the most current version.

(k) "Peer reviewed" means that a medical study's content, methodology and results have been evaluated and approved prior to publication by an editorial board of qualified experts.

(l) "Scientifically based" means based on scientific literature, wherein the body of literature is identified through performance of a literature search in MEDLINE, the identified literature is evaluated, and then used as the basis for the guideline.

(m) "Strength of Evidence" establishes the relative weight that shall be given to scientifically based evidence.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New article 5.5.2 (sections 9792.20-9792.23) and section filed 6-15-2007; operative 6-15-2007 pursuant to Government Code section 11343.4 (Register 2007, No. 24).

2. Amendment of subsection (b), new subsection (c), subsection relettering and amendment of newly designated subsection (g) filed 6-18-2009; operative 7-18-2009 pursuant to Government Code section 11343.4 (Register 2009, No. 25).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 5.5.2. Medical treatment utilization schedule

New query

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§9792.21 Medical Treatment Utilization Schedule.

(a) The Administrative Director adopts the Medical Treatment Utilization Schedule (MTUS) consisting of section 9792.20 through section 9792.26.

(b) The MTUS is intended to assist in the provision of medical treatment by offering an analytical framework for the evaluation and treatment of injured workers and to help those who make decisions regarding the medical treatment of injured workers understand what treatment has been proven effective in providing the best medical outcomes to those workers, in accordance with section 4600 of the Labor Code.

(c) Treatment shall not be denied on the sole basis that the condition or injury is not addressed by the MTUS. In this situation, the claims administrator shall authorize treatment if such treatment is in accordance with other scientifically and evidence-based, peer-reviewed, medical treatment guidelines that are nationally recognized by the medical community, in accordance with subdivisions (b) and (c) of section 9792.25, and pursuant to the Utilization Review Standards found in section 9792.6 through section 9792.10.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New section filed 6-15-2007; operative 6-15-2007 pursuant to GovernmentCode section 11343.4 (Register 2007, No. 24).

2. Amendment of subsection (a), renumbering of former subsection (a)(1) to section 9792.22, subsection (a), renumbering of former subsections (a)(2)-(a)(2)(E) to new section 9792.24.1 and amendment of subsections (b) and (c) filed 7-18-2009; operative 6-18-2009 pursuant to Government Code section11343.4 (Register 2009, No. 25).

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Subchapter 1. Administrative Director--Administrative Rules
Article 5.5.2. Medical treatment utilization schedule

New query

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§9792.22 General Approaches.

a) The Administrative Director adopts and incorporates by reference into the MTUS specific guidelines set forth below from the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM Practice Guidelines) for the following chapters. A copy may be obtained from the American College of Occupational and Environmental Medicine, 25 Northwest Point Blvd., Suite 700, Elk Grove Village, Illinois, 60007-1030 (www.acoem.org).

(1) Prevention (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 1).

(2) General Approach to Initial Assessment and Documentation (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 2).

(3) Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3).

(4) Cornerstones of Disability Prevention and Management (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 5).

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New section filed 6-15-2007; operative 6-15-2007 pursuant to GovernmentCode section 11343.4 (Register 2007, No. 24).

2. Amendment of section heading, renumbering of former section 9792.22 to section 9792.25, renumbering and amendment of former section 9792.21, subsection (a)(1) to section 9792.22, subsection (a) and new subsections (a)(1)-(4) filed 6-18-2009; operative 6-18-2009 pursuant to Government Codesection 11343.4 (Register 2009, No. 25).

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§9792.23.Clinical Topics.

(a) The Administrative Director adopts and incorporates by reference into the MTUS specific clinical topic medical treatment guidelines in the series of sections commencing with 9792.23.1 et seq. Clinical topics apply to the initial management and subsequent treatment of presenting complaints specific to the body part.

(b) For all conditions or injuries not addressed in the MTUS, the authorized treatment and diagnostic services in the initial management and subsequent treatment for presenting complaints shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community pursuant to section 9792.25(b).

(1) In providing treatment using other guidelines pursuant to subdivision (b) above and in the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply and supersede any applicable chronic pain guideline in accordance with section 9792.23(b).

(2) In providing treatment using other guidelines pursuant to subdivision (b) above and if surgery is performed, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS or in accordance with section 9792.23(b). The postsurgical treatment guidelines supersede any applicable postsurgical treatment guideline in accordance with section 9792.23(b).

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New section filed 6-15-2007; operative 6-15-2007 pursuant to GovernmentCode section 11343.4 (Register 2007, No. 24).

2. Renumbering of former section 9792.23 to section 9792.26 and new section 9792.23 filed 7-18-2009; operative 6-18-2009 pursuant to Government Codesection 11343.4 (Register 2009, No. 25).

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§9792.23.1. Neck and Upper Back Complaints.

(a) The Administrative Director adopts and incorporates by reference the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8) into the MTUS from the ACOEM Practice Guidelines.

(b) In the course of treatment for neck and upper back complaints where acupuncture or acupuncture with electrical stimulation is being considered, the acupuncture medical treatment guidelines in section 9792.24.1 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to acupuncture.

(c) If recovery has not taken place with respect to pain by the end of algorithm 8-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

(d) If surgery is performed in the course of treatment for neck and upper back complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New section filed 6-18-2009; operative 7-18-2009 pursuant to GovernmentCode section 11343.4 (Register 2009, No. 25).

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§ 9792.23.2. Shoulder Complaints.

(a) The Administrative Director adopts and incorporates by reference the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) into the MTUS from the ACOEM Practice Guidelines.

(b) If recovery has not taken place with respect to pain by the end of algorithm 9-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

(c) If surgery is performed in the course of treatment for shoulder complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New section filed 6-18-2009; operative 7-18-2009 pursuant to GovernmentCode section 11343.4 (Register 2009, No. 25).

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§9792.23.3. Elbow Disorders.

(a) The Administrative Director adopts and incorporates by reference the Elbow Disorders Chapter (ACOEM Practice Guidelines, 2nd Edition (Revised 2007), Chapter 10) into the MTUS from the ACOEM Practice Guidelines.

(b) In the course of treatment for elbow complaints where acupuncture or acupuncture with electrical stimulation is being considered, the acupuncture medical treatment guidelines in section 9792.24.1 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to acupuncture.

(c) If recovery has not taken place with respect to pain by the end of the Elbow Algorithm 10-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to chronic pain.

(d) If surgery is performed in the course of treatment for elbow complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New section filed 6-18-2009; operative 7-18-2009 pursuant to GovernmentCode section 11343.4 (Register 2009, No. 25).

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§9792.23.4. Forearm, Wrist, and Hand Complaints.

(a) The Administrative Director adopts and incorporates by reference the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11) into the MTUS from the ACOEM Practice Guidelines.

(b) In the course of treatment for forearm, wrist, and hand complaints where acupuncture or acupuncture with electrical stimulation is being considered, the acupuncture medical treatment guidelines in section 9792.24.1 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to acupuncture.

(c) If recovery has not taken place with respect to pain by the end of algorithm 11-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

(d) If surgery is performed in the course of treatment for forearm, wrist, and hand complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New section filed 6-18-2009; operative 7-18-2009 pursuant to GovernmentCode section 11343.4 (Register 2009, No. 25).

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§9792.23.6. Knee Complaints.

(a) The Administrative Director adopts and incorporates by reference the Knee Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 13) into the MTUS from the ACOEM Practice Guidelines.

(b) In the course of treatment for knee complaints where acupuncture or acupuncture with electrical stimulation is being considered, the acupuncture medical treatment guidelines in section 9792.24.1 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to acupuncture.

(c) If recovery has not taken place with respect to pain by the end of algorithm 13-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

(d) If surgery is performed in the course of treatment for knee complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New section filed 6-18-2009; operative 7-18-2009 pursuant to Government Code section 11343.4 (Register 2009, No. 25).

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§9792.23.7. Ankle and Foot Complaints.

(a) The Administrative Director adopts and incorporates by reference the Ankle and Foot Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 14) into the MTUS from the ACOEM Practice Guidelines.

(b) In the course of treatment for ankle and foot complaints where acupuncture or acupuncture with electrical stimulation is being considered, the acupuncture medical treatment guidelines in section 9792.24.1 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to acupuncture.

(c) If recovery has not taken place with respect to pain by the end of algorithm 14-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

(d) If surgery is performed in the course of treatment for ankle and foot complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New section filed 6-18-2009; operative 7-18-2009 pursuant to GovernmentCode section 11343.4 (Register 2009, No. 25).

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§9792.23.8. Stress Related Conditions.

(a) The Administrative Director adopts and incorporates by reference the Stress Related Conditions Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 15) into the MTUS from the ACOEM Practice Guidelines.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New section filed 6-18-2009; operative 7-18-2009 pursuant to GovernmentCode section 11343.4 (Register 2009, No. 25).

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§9792.23.9. Eye.

(a) The Administrative Director adopts and incorporates by reference the Eye Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 16) into the MTUS from the ACOEM Practice Guidelines.

(b) If recovery has not taken place with respect to pain by the end of algorithm 16-6, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New section filed 6-18-2009; operative 7-18-2009 pursuant to GovernmentCode section 11343.4 (Register 2009, No. 25).

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§9792.24. Special Topics.

(a) Special topics refer to clinical topic areas where the Administrative Director has determined that the clinical topic sections of the MTUS require further supplementation.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New section filed 6-18-2009; operative 7-18-2009 pursuant to GovernmentCode section 11343.4 (Register 2009, No. 25).

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§9792.24.1. Acupuncture Medical Treatment Guidelines.

(a) As used in this section, the following definitions apply:

(1) "Acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm.

(2) "Acupuncture with electrical stimulation" is the use of electrical current (micro-amperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

(3) "Chronic pain for purposes of acupuncture" means chronic pain as defined in section 9792.20(c).

(b) Application

(1) These guidelines apply to acupuncture or acupuncture with electrical stimulation when referenced in the clinical topic medical treatment guidelines in the series of sections commencing with 9792.23.1 et seq., or in the chronic pain medical treatment guidelines contained in section 9792.24.2.

(c) Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows:

(1) Time to produce functional improvement: 3 to 6 treatments.

(2) Frequency: 1 to 3 times per week

(3) Optimum duration: 1 to 2 months

(d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(f).

(e) It is beyond the scope of the Acupuncture Medical Treatment Guidelines to state the precautions, limitations, contraindications or adverse events resulting from acupuncture or acupuncture with electrical stimulations. These decisions are left up to the acupuncturist.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. Renumbering and amendment of former section 9792.21, subsections (a)(2)-(a)(2)(E) to new section 9792.24.1 filed 6-18-2009; operative 7-18-2009 pursuant to Government Code section 11343.4 (Register 2009, No. 25).

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§9792.24.2. Chronic Pain Medical Treatment Guidelines.

(a) The Chronic Pain Medical Treatment Guidelines (May, 2009), consisting of two parts, are adopted and incorporated by reference into the MTUS. Part 1 is entitled Introduction. Part 2 is entitled Pain Interventions and Treatments. These guidelines replace Chapter 6 of the ACOEM Practice Guidelines, 2nd Edition (2004). Where the clinical topic sections of the MTUS in the series of sections commencing with 9792.23.1 et seq., make reference to Chapter 6 or when there is a reference to the "pain chapter," or "pain assessment," the chronic pain medical treatment guidelines will apply instead of Chapter 6. A copy of the chronic pain medical treatment guidelines may be obtained from the Medical Unit, Division of Workers' Compensation, P.O. Box 71010, Oakland, CA 94612- 1486, or from the DWC web site at http://www.dwc.ca.gov.

(b) The chronic pain medical treatment guidelines apply when the patient has chronic pain as determined by following the clinical topics.

(c) When a patient is diagnosed with chronic pain and the treatment for the condition is covered in the clinical topics sections but is not addressed in the chronic pain medical treatment guidelines, the clinical topics section applies to that treatment.

(d) When the treatment is addressed in both the chronic pain medical treatment guidelines and the specific guideline found in the clinical topics section of the MTUS, the chronic pain medical treatment guideline shall apply.

(e) Appendix D-Chronic Pain Medical Treatment Guidelines-Division of Workers' Compensation and Official Disability Guidelines References (May, 2009)-is incorporated by reference into the MTUS as supplemental part of the Chronic Pain Medical Treatment Guidelines. A copy of Appendix D may be obtained from the Medical Unit, Division of Workers' Compensation, P.O. Box 71010, Oakland, CA 94612-1486, or from the DWC web site at http://www.dwc.ca.gov.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New section filed 6-18-2009; operative 7-18-2009 pursuant to GovernmentCode section 11343.4 (Register 2009, No. 25).

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§9792.24.3. Postsurgical Treatment Guidelines.

(a) As used in this section, the following definitions apply:

(1) "General course of therapy" means the number of visits and/or time interval which shall be indicated for postsurgical treatment for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section.

(2) "Initial course of therapy" means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section.

(3) "Postsurgical physical medicine period" means the time frame that is needed for postsurgical treatment and rehabilitation services beginning with the date of the procedure and ending at the time specified for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section. For all surgeries not covered by these guidelines the postsurgical physical medicine period is six (6) months.

(4) "Surgery" means a procedure listed in the surgery chapter of the Official Medical Fee Schedule with follow-up days of 90 days.

(5) "Visit" means a date of service to provide postsurgical treatment billed using the physical medicine section of the Official Medical Fee Schedule.

(b) Application

(1) The postsurgical treatment guidelines apply to visits during the postsurgical physical medicine period only and to surgeries as defined in these guidelines. At the conclusion of the postsurgical physical medicine period, treatment reverts back to the applicable 24-visit limitation for chiropractic, occupational and physical therapy pursuant to Labor Code section 4604.5(d)(1).

(c) Postsurgical Patient Management

(1) Only the surgeon who performed the operation, a nurse practitioner or physician assistant working with the surgeon, or a physician designated by that surgeon can make a determination of medical necessity and prescribe postsurgical treatment under this guideline.

(2) The medical necessity for postsurgical physical medicine treatment for any given patient is dependent on, but not limited to, such factors as the comorbid medical conditions; prior pathology and/or surgery involving same body part; nature, number and complexities of surgical procedure(s) undertaken; presence of surgical complications; and the patient's essential work functions.

(3) If postsurgical physical medicine is medically necessary, an initial course of therapy may be prescribed. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period.

(4) Patients shall be reevaluated following continuation of therapy when necessary or no later than every forty-five days from the last evaluation to document functional improvement to continue physical medicine treatment. Frequency of visits shall be gradually reduced or discontinued as the patient gains independence in management of symptoms and with achievement of functional goals.

(A) In the event the patient sustains an exacerbation related to the procedure performed after treatment has been discontinued and it is determined that more visits are medically necessary, physical medicine treatment shall be provided within the postsurgical physical medicine period.

(B) In cases where no functional improvement is demonstrated, postsurgical treatment shall be discontinued at any time during the postsurgical physical medicine period.

(5) Treatment is provided to patients to facilitate postsurgical functional improvement.

(A) The surgeon who performed the operation, a nurse practitioner or physician assistant working with the surgeon, or physician designated by that surgeon, the therapist, and the patient should establish functional goals achievable within a specified timeframe.

(B) Patient education regarding postsurgical precautions, home exercises, and self-management of symptoms should be ongoing components of treatment starting with the first visit. Intervention should include a home exercise program to supplement therapy visits.

(C) Modalities (CPT [as defined in section 9789.10(d)] codes 97010 through 97039) should only be performed in conjunction with other active treatments. Although these modalities are occasionally useful in the post surgical physical medicine period, their use should be minimized in favor of active physical rehabilitation and independent self-management.

(d) Postsurgical Physical Medicine Treatment Recommendations

(1) The postsurgical physical medicine treatment recommendations, as listed below, indicate frequency and duration of postsurgical treatment for specific surgeries. The specified surgeries in these guidelines are not all inclusive. Requests for postsurgical physical medicine treatment not included in these guidelines shall be considered pursuant to section 9792.21(c). The physical medicine treatment recommendations (listed alphabetically) are adapted from the Official Disability Guidelines (ODG) except where developed by the Division of Workers' Compensation and indicated as "[DWC]." The postsurgical physical medicine period is identified by an asterisk [*] as developed by DWC.

Postsurgical Treatment Guidelines

Ankle & Foot

Exercise program goals should include strength, flexibility, endurance, coordination, and education. Patients can be advised to do early passive range-of-motion exercises at home by a therapist. (Colorado, 2001) (Aldridge, 2004) This RCT (randomized controlled trial) supports early motion (progressing to full weight-bearing at 8 weeks from treatment) as an acceptable form of rehabilitation in surgically treated patients with Achilles tendon ruptures. (Twaddle, 2007)

Achilles tendon rupture (ICD9 727.67):

Postsurgical treatment: 48 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Ankle Sprain (ICD9 845.0):

Postsurgical treatment: 34 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Anterior tibial tendon [DWC]:

Postsurgical treatment: 8 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Amputation of foot (ICD9 896):

Post-replantation surgery: 48 visits over 26 weeks

*Postsurgical physical medicine treatment period: 12 months

Post-amputation treatment [DWC]: 48 visits over 26 weeks

*Postsurgical physical medicine treatment period: 12 months

Amputation of toe (ICD9 895):

Post-replantation surgery: 20 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Dislocation of the peroneal tendons [DWC]:

Postsurgical treatment: 8 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Enthesopathy of ankle and tarsus (ICD9 726.7):

Postsurgical treatment: 9 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Fracture of ankle (ICD9 824):

Postsurgical treatment: 21 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of ankle, Bimalleolar (ICD9 824.4):

Postsurgical treatment (ORIF): 21 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Postsurgical treatment (arthrodesis): 21 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of ankle, Trimalleolar (ICD9 824.6):

Postsurgical treatment: 21 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of one or more phalanges of foot (ICD9 826):

Postsurgical treatment: 12 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Special Consideration [DWC]: Postsurgical physical medicine is rarely needed for ganglionectomy.

Fracture of tibia and fibula (ICD9 823):

Postsurgical treatment (ORIF): 30 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Hallux rigidus (ICD9 735.2):

Postsurgical treatment: 9 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Hallux valgus (ICD9 735.0):

Postsurgical treatment: 9 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Hallux varus (ICD9 735.1):

Postsurgical treatment: 9 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Metatarsal stress fracture (ICD9 825):

Postsurgical treatment: 21 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Other hammer toe (ICD9 735.4):

Postsurgical treatment: 9 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Peroneal tendon repair [DWC]:

Postsurgical treatment: 8 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Posterior tibial tendonitis [DWC]:

Postsurgical treatment: 8 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Posterior tibial tenosynovitis (partial or complete rupture) [DWC]:

Postsurgical treatment: 8 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Burns

Recommended. Occupational therapy and physical therapy for the patient with burns may include respiratory management, edema management, splinting and positioning, physical function (mobility, function, exercise), scar management, and psychosocial elements. (Simons, 2003) As with any treatment, if there is no improvement after 2-3 weeks the protocol may be modified or re-evaluated.

Burns (ICD9 949):

Postsurgical treatment: 16 visits over 8 weeks

*Postsurgical physical medicine treatment period: 6 months

Cardiopulmonary [DWC]:

Coronary Stenting [DWC]:

Postsurgical treatment: 36 visits over 18 weeks

*Postsurgical physical medicine treatment period: 6 months

Heart Valve repair/replacement [DWC]:

Postsurgical treatment: 36 visits over 18 weeks

*Postsurgical physical medicine treatment period: 6 months

Percutaneous transluminal coronary angioplasty (PTCA) [DWC]:

Postsurgical treatment: 36 visits over 18 weeks

*Postsurgical physical medicine treatment period: 6 months

Carpal Tunnel Syndrome

Recommended as indicated below. There is limited evidence demonstrating the effectiveness of PT (physical therapy) or OT (occupational therapy) for CTS (carpal tunnel syndrome). The evidence may justify 3 to 5 visits over 4 weeks after surgery, up to the maximums shown below. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal tunnel syndrome should not result in extended time off work while undergoing multiple therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is a relatively simple operation that

also should not require extended multiple therapy office visits for recovery. Of course, these statements do not apply to cases of failed surgery and/or misdiagnosis (e.g., CRPS (complex regional pain syndrome) I instead of CTS). (Feuerstein, 1999) (O'Conner-Cochrane, 2003) (Verhagen-Cochrane, 2004) (APTA, 2006) (Bilic, 2006) Post surgery, a home therapy program is superior to extended splinting. (Cook, 1995) Continued visits should be contingent on documentation of objective improvement, i.e., VAS (visual analog scale) improvement greater than four, and long-term resolution of symptoms. Therapy should include education in a home program, work discussion and suggestions for modifications, lifestyle changes, and setting realistic expectations. Passive modalities, such as heat, iontophoresis, phonophoresis, ultrasound and electrical stimulation, should be minimized in favor of active treatments.

Carpal tunnel syndrome (ICD9 354.0):

Postsurgical treatment (endoscopic): 3-8 visits over 3-5 weeks

*Postsurgical physical medicine treatment period: 3 months

Postsurgical treatment (open): 3-8 visits over 3-5 weeks

*Postsurgical physical medicine treatment period: 3 months

Elbow & Upper Arm

Arthropathy, unspecified (ICD9 716.9):

Postsurgical treatment, arthroplasty, elbow: 24 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Cubital tunnel release [DWC]:

Postsurgical treatment: 20 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Dislocation of elbow (ICD9 832):

Unstable dislocation, postsurgical treatment: 10 visits over 9 weeks

*Postsurgical physical medicine treatment period: 4 months

ECRB / ECRL debridement [DWC]:

Postsurgical treatment: 10 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

ECRB / ECCRL tenotomy [DWC]:

Postsurgical treatment: 10 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Elbow diagnostic arthroscopy and arthroscopic debridement [DWC]:

Postsurgical treatment: 20 visits over 2 months

*Postsurgical physical medicine treatment period: 4 months

Elbow collateral ligament repair [DWC]:

Postsurgical treatment: 14 visits over 6 months

*Postsurgical physical medicine treatment period: 8 months

Enthesopathy of elbow region (ICD9 726.3):

Postsurgical treatment: 12 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of humerus (ICD9 812):

Postsurgical treatment: 24 visits over 14 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of radius/ulna (ICD9 813):

Postsurgical treatment: 16 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Lateral epicondylitis/Tennis elbow (ICD9 726.32):

Postsurgical treatment: 12 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Medial epicondylitis/Golfers' elbow (ICD9 726.31):

Postsurgical treatment: 12 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Muscle or tendon transfers for elbow flexion [DWC]:

Postsurgical treatment: 30 visits over 5 months

*Postsurgical physical medicine treatment period: 8 months

Rupture of biceps tendon (ICD9 727.62):

Postsurgical treatment: 24 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Sprains and strains of elbow and forearm (ICD9 841):

Postsurgical treatment/ligament repair: 24 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Traumatic amputation of arm (ICD9 887):

Post-amputation treatment: without complications, no prosthesis [DWC]: 18 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Post-amputation treatment: without complications, with prosthesis [DWC]: 30 visits over 6 months

*Postsurgical physical medicine treatment period: 9 months

Post-amputation treatment: with complications, no prosthesis [DWC]: 30 visits over 5 months

*Postsurgical physical medicine treatment period: 7 months

Post-amputation treatment: with complications and prosthesis [DWC]: 40 visits over 8 months

*Postsurgical physical medicine treatment period: 12 months

Post-replantation surgery: 48 visits over 26 weeks

*Postsurgical physical medicine treatment period: 12 months

Triceps repair [DWC]:

Postsurgical treatment: 24 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Ulnar nerve entrapment/Cubital tunnel syndrome (ICD9 354.2):

Postsurgical treatment: 20 visits over 10 weeks

*Postsurgical physical medicine treatment period: 6 months

Forearm, Wrist, & Hand

(Not including Carpal Tunnel Syndrome - see separate post surgical guideline.)

Used after surgery and amputation. During immobilization, there was weak evidence of improved hand function in the short term, but not in the longer term, for early occupational therapy, and of a lack of differences in outcome between supervised and unsupervised exercises. Post-immobilization, there was weak evidence of a lack of clinically significant differences in outcome in patients receiving formal rehabilitation therapy, passive mobilization or whirlpool immersion compared with no intervention. There was weak evidence of a short-term benefit of continuous passive motion (post external fixation), intermittent pneumatic compression and ultrasound. There was weak evidence of better short-term hand function in patients given therapy than in those given instructions for home exercises by a surgeon. (Handoll-Cochrane, 2002) (Handoll-Cochrane, 2006)

Amputation of arm, below the elbow [DWC]:

Post-amputation treatment: without complications, no prosthesis: 18 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Post-amputation: without complications, with prosthesis: 30 visits over 6 months

*Postsurgical physical medicine treatment period: 9 months

Post-amputation: with complications, no prosthesis: 30 visits over 5 months

*Postsurgical physical medicine treatment period: 7 months

Post-amputation: with complications and prosthesis: 40 visits over 8 months

*Postsurgical physical medicine treatment period: 12 months

Amputation of hand (ICD9 887):

Post-amputation treatment: without complications, no prosthesis [DWC]: 18 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Post-amputation treatment: with complications, no prosthesis [DWC]: 24 visits over 5 months

*Postsurgical physical medicine treatment period: 7 months

Post-replantation surgery: 48 visits over 26 weeks

*Postsurgical physical medicine treatment period: 12 months

Amputation of thumb; finger (ICD9 885; 886):

Post-replantation surgery: 36 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Post-amputation: Amputation of fingers without replantation [DWC]: 14 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Post-amputation: Amputation of thumb without replantation [DWC]: 16 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Arthropathy, unspecified (ICD9 716.9):

Postsurgical treatment, arthroplasty/fusion, wrist/finger: 24 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Contracture of palmar fascia (Dupuytren's) (ICD9 728.6):

Postsurgical treatment: 12 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Digital nerve repair [DWC]:

Postsurgical treatment: 8 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

DIP joint intraarticular fracture at middle or distal phalanx [DWC]:

Postsurgical treatment: 14 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Dislocation of finger (ICD9 834):

Postsurgical treatment: 16 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Dislocation of wrist (ICD9 833):

Postsurgical treatment (TFCC reconstruction): 16 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Extensor tendon repair or tenolysis [DWC]:

Postsurgical treatment: 18 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Extensor tenosynovectomy [DWC]:

Postsurgical treatment: 14 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Flexor tendon repair or tenolysis Zone 2 and other than Zone 2 [DWC]:

Postsurgical treatment: Flexor tendon repair or tenolysis Zone 2: 30 visits over 6 months

*Postsurgical physical medicine treatment period: 8 months

Postsurgical treatment: Other than Zone 2: 20 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Flexor tenosynovectomy [DWC]:

Postsurgical treatment: 14 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Flexor tendon repair (forearm) [DWC]:

Postsurgical treatment: 12 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Fracture of carpal bone (wrist) (ICD9 814):

Postsurgical treatment: 16 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Fracture of metacarpal bone (hand) (ICD9 815):

Postsurgical treatment: 16 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Fracture of one or more phalanges of hand (fingers) (ICD9 816):

Postsurgical treatment: Complicated, 16 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Fracture of radius/ulna (forearm) (ICD9 813):

Postsurgical treatment: 16 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Ganglion and cyst of synovium, tendon, and bursa (ICD9 727.4):

Postsurgical treatment: 18 visits over 6 weeks

*Special Consideration: Postsurgical physical medicine is rarely needed for ganglionectomy.

Intersection syndrome [DWC]:

Postsurgical treatment: 9 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Median Nerve Repair: Forearm - Wrist [DWC]:

Postsurgical treatment: 20 visits over 6 weeks

*Postsurgical physical medicine treatment period: 6 months

PIP and MCP capsulotomy/capsulectomy [DWC]:

Postsurgical treatment: 24 visits over 2 months

*Postsurgical physical medicine treatment period: 4 months

PIP and MCP collateral ligament reconstruction [DWC]:

Postsurgical treatment: 18 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

PIP and MCP collateral ligament repairs [DWC]:

Postsurgical treatment: 12 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

PIP joint intraarticular fracture and or dislocation at proximal or middle phalanx [DWC]:

Postsurgical treatment: Postsurgical treatment: 20 visits over 6 months

*Postsurgical physical medicine treatment period: 8 months

Proximal row carpectomy [DWC]:

Postsurgical treatment:20 visits over 6 months

*Postsurgical physical medicine treatment period: 8 months

Nerve Repair: Elbow - Wrist [DWC]

Postsurgical treatment: 20 visits over 6 weeks

*Postsurgical physical medicine treatment period: 8 months

Radial styloid tenosynovitis (de Quervain's) (ICD9 727.04):

Postsurgical treatment: 14 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Sprains and strains of elbow and forearm (ICD9 841):

Post-surgical treatment/ligament repair: 24 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Synovitis and tenosynovitis (ICD9 727.0):

Postsurgical treatment: 14 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Tendon transfer forearm, wrist or hand [DWC]:

Postsurgical treatment: 14 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Tendon transfers - thumb or finger [DWC]:

Postsurgical treatment: 26 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

TFCC injuries-debridement (arthroscopic) [DWC]:

Postsurgical treatment:10 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Trigger finger (ICD9 727.03):

Postsurgical treatment: 9 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Ulnar nerve entrapment/Cubital tunnel syndrome (ICD9 354.2):

Postsurgical treatment: 20 visits over 10 weeks

*Postsurgical physical medicine treatment period: 6 months

Wrist - intercarpal ligament reconstruction or repair [DWC]:

Postsurgical treatment 20 visits over 6 months

*Postsurgical physical medicine treatment period: 8 months

Head

Patient rehabilitation after traumatic brain injury is divided into two periods: acute and subacute. In the beginning of rehabilitation therapist evaluates patient's functional status, later he uses methods and means of treatment, and evaluates effectiveness of rehabilitation. Early ambulation is very important for patients with coma. Therapy consists of prevention of complications, improvement of muscle force, and range of motions, balance, movement coordination, endurance and cognitive functions. Early rehabilitation is necessary for traumatic brain injury patients and use of therapy methods can help to regain lost functions and to come back to the society. (Colorado, 2005) (Brown, 2005) (Franckeviciute, 2005) (Driver, 2004) (Shiel, 2001)

Fracture of skull (ICD9 801):

Postsurgical treatment: 34 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Hernia

Not recommended. No evidence of successful outcomes compared to surgery.

Hip, Pelvis and Thigh (femur)

A therapy program that starts immediately following hip surgery allows for greater improvement in muscle strength, walking speed and functional score. (Jan, 2004) (Jain, 2002) (Penrod, 2004) (Tsauo, 2005) (Brigham, 2003) (White, 2005) (National, 2003) A weight-bearing exercise program can improve balance and functional ability to a greater extent than a non-weight-bearing program. (Expert, 2004) (Binder, 2004) (Bolgla, 2005) (Handoll, 2004) (Kuisma, 2002) (Lauridsen, 2002) (Mangione, 2005) (Sherrington, 2004) Patients with hip fracture should be offered a coordinated multidisciplinary rehabilitation program with the specific aim of regaining sufficient function to return to their pre-fracture living arrangements. (Cameron, 2005) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008)

Arthrodesis [DWC]:

Postsurgical treatment: 22 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Arthropathy, unspecified (ICD9 716.9):

Postsurgical treatment, arthroplasty/fusion, hip: 24 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Fracture of neck of femur (ICD9 820):

Postsurgical treatment: 24 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Fracture of pelvis (ICD9 808):

Postsurgical treatment: 24 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Osteoarthrosis and allied disorders (ICD9 715):

Post-surgical treatment: 18 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Synovectomy [DWC]:

Postsurgical treatment: 14 visits over 3 months

*Postsurgical physical medicine treatment period: 6 months

Knee

Controversy exists about the effectiveness of therapy after arthroscopic partial meniscectomy. (Goodwin, 2003) Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term therapy interventions with exercises based on functional activities may be more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. (Minns Lowe, 2007) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008)

Amputation of leg (ICD9 897):

Post-replantation surgery: 48 visits over 26 weeks

*Postsurgical physical medicine treatment period: 12 months Post-amputation [DWC]: 48 visits over 6 months

*Postsurgical physical medicine treatment period: 8 months

Arthritis (Arthropathy, unspecified) (ICD9 716.9):

Postsurgical treatment, arthroplasty, knee: 24 visits over 10 weeks

*Postsurgical physical medicine treatment period: 4 months

Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella (ICD9 836; 836.0; 836.1; 836.2; 836.3; 836.5):

Postsurgical treatment: (Meniscectomy): 12 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of neck of femur (ICD9 820):

Postsurgical treatment: 18 visits over 8 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of other and unspecified parts of femur (ICD9 821):

Postsurgical treatment: 30 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of patella (ICD9 822):

Postsurgical treatment: 10 visits over 8 weeks

*Postsurgical physical medicine treatment period: 4 months

Fracture of tibia and fibula (ICD9 823):

Postsurgical treatment (ORIF): 30 visits over 12 weeks

*Postsurgical physical medicine treatment period: 6 months

Manipulation under Anesthesia (knee) [DWC]:

Postsurgical treatment: 20 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Old bucket handle tear; Derangement of meniscus; Loose body in knee; Chondromalacia of patella; Tibialis tendonitis (ICD9 717.0; 717.5; 717.6; 717.7; 726.72):

Postsurgical treatment: 12 visits over 12 weeks

*Postsurgical physical medicine treatment period: 4 months

Sprains and strains of knee and leg; Cruciate ligament of knee (ACL tear) (ICD9 844; 844.2):

Postsurgical treatment: (ACL repair): 24 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Low Back

As compared with no therapy, therapy (up to 20 sessions over 12 weeks) following disc herniation surgery was effective. Because of the limited benefits of therapy relative to massage, it is open to question whether this treatment acts primarily physiologically, but psychological factors may contribute substantially to the benefits observed. (Erdogmus, 2007)

Artificial Disc [DWC]:

Postsurgical treatment: 18 visits over 4 months

*Postsurgical physical medicine treatment period: 6 months

Fracture of vertebral column with spinal cord injury (ICD9 806):

Postsurgical treatment: 48 visits over 18 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of vertebral column without spinal cord injury (ICD9 805):

Postsurgical treatment: 34 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Intervertebral disc disorder with myelopathy (ICD9 722.7):

Postsurgical treatment: 48 visits over 18 weeks

*Postsurgical physical medicine treatment period: 6 months

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):

Postsurgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

*Postsurgical physical medicine treatment period: 6 months

Postsurgical treatment (arthroplasty): 26 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Postsurgical treatment (fusion): 34 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Spinal stenosis (ICD9 724.0):

See 722.1 for postsurgical visits

*Postsurgical physical medicine treatment period: 6 months

Neck & Upper Back

Displacement of cervical intervertebral disc (ICD9 722.0):

Postsurgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

*Postsurgical physical medicine treatment period: 6 months

Postsurgical treatment (fusion, after graft maturity): 24 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Degeneration of cervical intervertebral disc (ICD9 722.4):

See 722.0 for postsurgical visits

*Postsurgical physical medicine treatment period: 6 months

Fracture of vertebral column without spinal cord injury (ICD9 805):

Postsurgical treatment: 34 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of vertebral column with spinal cord injury (ICD9 806):

Postsurgical treatment: 48 visits over 18 weeks

*Postsurgical physical medicine treatment period: 6 months

Shoulder

Acromioclavicular joint dislocation (ICD9 831.04):

AC separation, type III+: 8 visits over 8 weeks

*Postsurgical physical medicine treatment period: 6 months

Adhesive capsulitis (ICD9 726.0):

Postsurgical treatment: 24 visits over 14 weeks

*Postsurgical physical medicine treatment period: 6 months

Arthritis (Osteoarthrosis; Rheumatoid arthritis; Arthropathy, unspecified) (ICD9 714.0; 715; 715.9; 716.9):

Postsurgical treatment, arthroplasty, shoulder: 24 visits over 10 weeks

*Postsurgical physical medicine treatment period: 6 months

Brachial plexus lesions (Thoracic outlet syndrome) (ICD9 353.0):

Postsurgical treatment: 20 visits over 10 weeks

*Postsurgical physical medicine treatment period: 6 months

Complete rupture of rotator cuff (ICD9 727.61; 727.6):

Postsurgical treatment: 40 visits over 16 weeks

*Postsurgical physical medicine treatment period: 6 months

Dislocation of shoulder (ICD9 831):

Postsurgical treatment (Bankart): 24 visits over 14 weeks

*Postsurgical physical medicine treatment period: 6 months

Fracture of humerus (ICD9 812):

Postsurgical treatment: 24 visits over 14 weeks

*Postsurgical physical medicine treatment period: 6 months

Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):

Postsurgical treatment, arthroscopic: 24 visits over 14 weeks

*Postsurgical physical medicine treatment period: 6 months

Postsurgical treatment, open: 30 visits over 18 weeks

*Postsurgical physical medicine treatment period: 6 months

Sprained shoulder; rotator cuff (ICD9 840; 840.4):

Postsurgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks

*Postsurgical physical medicine treatment period: 6 months

(2) Appendix C - Postsurgical Treatment Guidelines Evidence-Based Reviews (May, 2009)- is incorporated by reference into the MTUS as supplemental part of the Postsurgical Treatment Guidelines. A copy of Appendix C may be obtained from the Medical Unit, Division of Workers' Compensation, P.O. Box 71010, Oakland, CA 94612-1486, or from the DWC web site at http://www.dwc.ca.gov.

(3) Appendix E - Postsurgical Treatment Guidelines Work Loss Data Institute-Official Disability Guidelines References (May, 2009) - is incorporated by reference into the MTUS as supplemental part of the Postsurgical Treatment Guidelines. A copy of Appendix E may be obtained from the Medical Unit, Division of Workers' Compensation, P.O. Box 71010, Oakland, CA 94612-1486, or from the DWC web site at http://www.dwc.ca.gov.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. New section filed 6-18-2009; operative 7-18-2009 pursuant to GovernmentCode section 11343.4 (Register 2009, No. 25).

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New query

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§9792.25. Presumption of Correctness, Burden of Proof and Strength of Evidence.

(a) The MTUS is presumptively correct on the issue of extent and scope of medical treatment and diagnostic services addressed in the MTUS for the duration of the medical condition. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the schedule is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof.
(b) For all conditions or injuries not addressed by the MTUS, authorized treatment and diagnostic services shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community.

(c)(1) For conditions or injuries not addressed by either subdivisions (a) or (b) above; for medical treatment and diagnostic services at variance with both subdivisions (a) and (b) above; or where a recommended medical treatment or diagnostic service covered under subdivision (b) is at variance with another treatment guideline also covered under subdivision (b), the following ACOEM's strength of evidence rating methodology is adopted and incorporated as set forth below, and shall be used to evaluate scientifically based evidence published in peer-reviewed, nationally recognized journals to recommend specific medical treatment or diagnostic services:

(A) Table A - Criteria Used to Rate Randomized Controlled Trials

Studies shall be rated using the following 11 criteria. Each criterion shall be rated 0, 0.5, or 1.0, thus the overall ratings range from 0-11. A study is considered low quality if the composite rating was 3.5 or less, intermediate quality if rated 4-7.5, and high quality if rated 8-11.

Criteria	Rating Explanation
Randomization: Assessment of the degree that randomization was both reported to have been performed and successfully* achieved through analyses of comparisons of variables between the two groups. *Simply allocating individuals to groups does	Rating is “0” if the study is not randomized or reports that it was and subsequent analyses of the data/tables suggest it either was not randomized or was unsuccessful. Rating is “0.5” if there is mention of randomization and it appears as if it was performed, however there are no data on the success of randomization, it appears incomplete, or other questions about randomization cannot be adequately addressed. Rating is “1.0” if randomization is specifically stated and data reported on subgroups suggests that the study did

not constitute sufficient grounds to assess the success of randomization. The groups must be comparable; otherwise, the randomization was unsuccessful.	achieve successful randomization.
Treatment Allocation Concealed: Concealment of the allocation scheme from all involved, not just the patient.	Rating is “0” if there is no description of how members of the research team or subjects would have not been able to know how they were going to receive a particular treatment, or the process used would not be concealed. Rating is “0.5” if the article mentions how allocation was concealed, but the concealment was either partial involving only some of those involved or other questions about it are unable to be completely addressed. Rating is “1.0” if there is a concealment process described that would conceal the treatment allocation to all those involved.
Baseline Comparability: Measures how well the baseline groups are comparable (e.g., age, gender, prior treatment).	Rating is “0” if analyses show that the groups were dissimilar at baseline or it cannot be assessed. Rating is “0.5” if there is general comparability, though one variable may not be comparable. Rating is “1.0” if there is good comparability for all variables between the groups at baseline.
Patient Blinded	Rating is “0” if there is no mention of blinding of the patient. Rating is “0.5” if it mentions blinding, but the methods are unclear. Rating is “1.0” if the study reports blinding, describes how that was carried out, and would plausibly blind the patient.
Provider Blinded	Rating is “0” if there is no mention of blinding of the provider. Rating is “0.5” if it mentions blinding, but the methods are unclear. Rating is “1.0” if the study reports blinding, describes how that was carried out and would plausibly blind the provider.
Assessor Blinded	Rating is “0” if there is no mention of blinding of the

	assessor. Rating is “0.5” if it mentions blinding, but the methods are unclear. Rating is “1.0” if the study reports blinding, describes how that was carried out and would plausibly blind the assessor.
Controlled for Co-interventions: The degree to which the study design controlled for multiple interventions (e.g., a combination of stretching exercises and anti-inflammatory medication or mention of not using other treatments during the study).	Rating is “0” if there are multiple interventions or no description of how this was avoided. Rating is “0.5” if there is brief mention of this potential problem. Rating is “1.0” if there is a detailed description of how co-interventions were avoided.
Compliance Acceptable: Measures the degree of non-compliance.	Rating is “0” if there is no mention of non-compliance. Rating is “0.5” if non-compliance is briefly addressed and the description suggests that there was compliance, but a complete assessment is not possible. Rating is “1.0” if there are specific data and the non-compliance rate is less than 20%.
Dropout Rate: Measures the drop-out rate.	Rating is “0” if there is no mention of drop-outs or it cannot be inferred from the data presented. Rating is “0.5” if the drop-out issue is briefly addressed and the description suggests that there were few drop-outs, but a complete assessment is not possible. Rating is “1.0” if there are specific data and the drop-out rate is under 20%.
Timing of Assessments: Timing rates the timeframe for the assessments between the study groups.	Rating is “0” if the timing of the evaluations is different between the groups. Rating is “0.5” if the timing is nearly identical (e.g., one day apart). Rating is “1.0” if the timing of the assessments between the groups is identical.

Analyzed by Intention to Treat: This rating is for whether the study was analyzed with an intent to treat analysis.	Rating is “0” if it was not analyzed by intent to treat. Rating is “0.5” if there is not mention of intent to treat analysis, but the results would not have been different (e.g., there was nearly 100% compliance and no drop-outs). Rating is “1.0” if the study specifies analyses by intention to treat.
Lack of Bias: This rating does not enter into the overall rating of an article. This is an overall indication of the degree to which biases are felt to be present in the study.	Rating is “0” if there are felt to be significant biases that are uncontrolled in the study and may have influenced the study’s results. Rating is “0.5” if there are felt to be some biases present, but the results are less likely to have been influenced by those biases. Rating is “1.0” if there are few biases, or those are well controlled and unlikely to have influenced the study’s results.

(B) Table B - Strength of Evidence Ratings

Levels of evidence shall be used to rate the quality of the body of evidence. The body of evidence shall consist of all studies on a given topic that are used to develop evidence-based recommendations. Levels of evidence shall be applied when studies are relevant to the topic and study working populations. Study outcomes shall be consistent and study data shall be homogeneous.

A	**Strong evidence-base**: One or more well-conducted systematic reviews or meta-analyses, or two or more high-quality studies.
B	**Moderate evidence-base**: At least one high-quality study, a well-conducted systematic review or meta-analysis of lower quality studies or multiple lower-quality studies relevant to the topic and the working population.
C	**Limited evidence-base**: At least one study of intermediate quality.
I	**Insufficient Evidence**: Evidence is insufficient or irreconcilable.

(2) Evidence shall be given the highest weight in the order of the strength of evidence.

Note: Authority: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. Renumbering and amendment of former section 9792.22 to new section 9792.25 filed 6-18-2009; operative 7-18-2009 pursuant to Government Code section11343.4 (Register 2009, No. 25).

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New query

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§9792.26. Medical Evidence Evaluation Advisory Committee.

(a)(1) The Medical Director shall create a medical evidence evaluation advisory committee to provide recommendations to the Medical Director on matters concerning the MTUS. The recommendations are advisory only and shall not constitute scientifically based evidence.

(A) If the Medical Director position becomes vacant, the Administrative Director shall appoint a competent person to temporarily assume the authority and duties of the Medical Director as set forth in this section, until such time that the Medical Director position is filled.

(2) The members of the medical evidence evaluation advisory committee shall be appointed by the Medical Director, or his or her designee, and shall consist of 17 members of the medical community holding the following licenses: Medical Doctor (M.D.) board certified by an American Board of Medical Specialties (ABMS) approved specialty board; Doctor of Osteopathy (D.O.) board certified by an ABMS or American Osteopathic Association (AOA) approved specialty board; M.D. board certified by a Medical Board of California (MBC) approved specialty board; Doctor of Chiropractic (D.C.); Physical Therapy (P.T.); Occupational Therapy (O.T.); Acupuncture (L.Ac.); Psychology (PhD.); or Doctor of Podiatric Medicine (DPM), and representing the following specialty fields:

(A) One member shall be from the orthopedic field;

(B) One member shall be from the chiropractic field;

(C) One member shall be from the occupational medicine field;

(D) One member shall be from the acupuncture medicine field;

(E) One member shall be from the physical therapy field;

(F) One member shall be from the psychology field;

(G) One member shall be from the pain specialty field;

(H) One member shall be from the occupational therapy field;

(I) One member shall be from the psychiatry field;

(J) One member shall be from the neurosurgery field;

(K) One member shall be from the family physician field;

(L) One member shall be from the neurology field;

(M) One member shall be from the internal medicine field;

(N) One member shall be from the physical medicine and rehabilitation field;

(O) One member shall be from the podiatrist field;

(P) Two additional members shall be appointed at the discretion of the Medical Director or his or her designee.

(3) In addition to the seventeen members of the medical evidence evaluation advisory committee appointed under subdivision (a)(2) above, the Medical Director, or his or her designee, may appoint an additional three members to the medical evidence evaluation advisory committee as subject matter experts for any given topic.

(b) The Medical Director, or his or her designee, shall serve as the chairperson of the medical evidence evaluation advisory committee.

(c) To evaluate evidence when making recommendations to revise, update or supplement the MTUS, the members of the medical evidence evaluation advisory committee shall:

(1) Apply the requirements of subdivision (b) of section 9792.25 in reviewing medical treatment guidelines to insure that the guidelines are scientifically and evidence-based, and nationally recognized by the medical community;

(2) Apply the ACOEM's strength of evidence rating methodology to the scientific evidence as set forth in subdivision (c) of section 9792.25 after identifying areas in the guidelines which do not meet the requirements set forth in subdivision (b) of section 9792.25;

(3) Apply in reviewing the scientific evidence, the ACOEM's strength of evidence rating methodology for treatments where there are no medical treatment guidelines or where a guideline is developed by the Administrative Director, as set forth in subdivision (c) of section 9792.25.

(d) The members of the medical evidence evaluation advisory committee, except for the three subject matter experts, shall serve a term of two year period, but shall remain in that position until a successor is selected. The subject matter experts shall serve as members of the medical evidence evaluation advisory committee until the evaluation of the subject matter guideline is completed. The members of the committee shall meet as necessary, but no less than four (4) times a year.

(e) The Administrative Director, in consultation with the Medical Director, may revise, update, and supplement the MTUS as necessary.

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

HISTORY

1. Renumbering and amendment of former section 9792.23 to new section 9792.26 filed 6-18-2009; operative 7-18-2009 pursuant to Government Code section11343.4 (Register 2009, No. 25).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 5.6. Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations

New query

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§9793. Definitions.

As used in this article:

(a) "Claim" means a claim for compensation as evidenced by either the filing of a claim form pursuant to Section 5401 of the Labor Code or notice or knowledge of an injury under Section 5400 or 5402 of the Labor Code.

(b) "Contested claim" means any of the following:

(1) Where the claims administrator has rejected liability for a claimed benefit.

(2) Where the claims administrator has failed to accept liability for a claim and the claim has become presumptively compensable under Section 5402 of the Labor Code.

(3) Where the claims administrator has failed to respond to a demand for the payment of compensation after the expiration of any time period fixed by statute for the payment of indemnity benefits, including where the claims administrator has failed to either commence the payment of temporary disability indemnity or issue a notice of delay within 14 days after knowledge of an employee's injury and disability as provided in Section 4650 of the Labor Code.

(4) Where the claims administrator has accepted liability for a claim and a disputed medical fact exists.

(c) "Comprehensive medical-legal evaluation" means an evaluation of an employee which (A) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606 and (B) is either:

(1) performed by a Qualified Medical Evaluator pursuant to subdivision (h) of Section 139.2 of the Labor Code, or

(2) performed by a Qualified Medical Evaluator, Agreed Medical Evaluator, or the primary treating physician for the purpose of proving or disproving a contested claim, and which meets the requirements of paragraphs (1) through (5), inclusive, of subdivision (g).

(d) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, a group self-insurer, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, group self-insurer, or joint powers authority.

(e) "Disputed medical fact" means an issue in dispute, including an objection to a medical determination made by a

treating physician under Section 4062 of the Labor Code, concerning (1) the employee's medical condition, (2) the cause of the employee's medical condition, (3) treatment for the employee's medical condition, (4) the existence, nature, duration or extent of temporary or permanent disability caused by the employee's medical condition, or (5) the employee's medical eligibility for rehabilitation services.

(f) "Follow-up medical-legal evaluation" means an evaluation which includes an examination of an employee which (A) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606, (B) is performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician within nine months following the evaluator's examination of the employee in a comprehensive medical-legal evaluation and (C) involves an evaluation of the same injury or injuries evaluated in the comprehensive medical- legal evaluation.

(g) "Medical-legal expense" means any costs or expenses incurred by or on behalf of any party or parties, the administrative director, or the appeals board for X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and as needed, interpreter's fees, for the purpose of proving or disproving a contested claim. The cost of medical evaluations, diagnostic tests, and interpreters is not a medical-legal expense unless it is incidental to the production of a comprehensive medical-legal evaluation report, follow-up medical-legal evaluation report, or a supplemental medical-legal evaluation report and all of the following conditions exist:

(1) The report is prepared by a physician, as defined in Section 3209.3 of the Labor Code.

(2) The report is obtained at the request of a party or parties, the administrative director, or the appeals board for the purpose of proving or disproving a contested claim and addresses the disputed medical fact or facts specified by the party, or parties or other person who requested the comprehensive medical-legal evaluation report. Nothing in this paragraph shall be construed to prohibit a physician from addressing additional related medical issues.

(3) The report is capable of proving or disproving a disputed medical fact essential to the resolution of a contested claim, considering the substance as well as the form of the report, as required by applicable statutes, regulations, and case law.

(4) The medical-legal examination is performed prior to receipt of notice by the physician, the employee, or the employee's attorney, that the disputed medical fact or facts for which the report was requested have been resolved.

(5) In the event the comprehensive medical-legal evaluation is served on the claims administrator after the disputed medical fact or facts for which the report was requested have been resolved, the report is served within the time frame specified in Section 139.2(j)(1) of the Labor Code.

(h) "Medical-legal testimony" means expert testimony provided by a physician at a deposition or workers' compensation appeals board hearing, regarding the medical opinion submitted by the physician.

(i) "Medical research" is the investigation of medical issues. It includes investigating and reading medical and scientific journals and texts. "Medical research" does not include reading or reading about theGuides for the Evaluation of Permanent Impairment (any edition), treatment guidelines (including guidelines of the American College of Occupational and Environmental Medicine), the Labor Code, regulations or publications of the Division of Workers' Compensation (including thePhysicians' Guide), or other legal materials.

(j) "Primary treating physician" is the treating physician primarily responsible for managing the care of the injured worker in accordance with subdivision (a) of Section 9785.

(k) "Reports and documents required by the administrative director" means an itemized billing, a copy of the medical-legal evaluation report, and any verification required under Section 9795(c).

(l) "Supplemental medical-legal evaluation" means an evaluation which (A) does not involve an examination of the patient, (B) is based on the physician's review of records, test results or other medically relevant information which

was not available to the physician at the time of the initial examination, (C) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606 and (D) is performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician following the evaluator's completion of a comprehensive medical-legal evaluation.

Note: Authority cited: Sections 133, 4627, 5307.3 and 5307.6, Labor Code. Reference: Sections 4061, 4061.5, 4062, 4620, 4621, 4622, 4625, 4628, 4650, 5307.6 and 5402, Labor Code.

HISTORY

1. New article 5.6 (sections 9793-9795) filed 1-10-85; designated effective 3-1-85 (Register 85, No. 2).

2. Change without regulatory effect filed 7-11-86; effective upon filing (Register 86, No. 28).

3. Repealer and new section filed 8-3-93; operative 8-3-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 32).

4. Amendment of article heading, section and Notefiled 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section11351 (Register 93, No. 53).

5. Change without regulatory effect amending subsections (f) and (i) filed 6-12-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 24).

6. Amendment of subsections (a) and (b)(3), new subsection (i), subsection relettering and amendment of newly designated subsection (j) filed 6-30-2006; operative 7-1-2006. Submitted to OAL for filing with the Secretary of State and printing only pursuant to Government Code section 11340.9(g) (Register 2006, No. 26).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 5.6. Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations

New query

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§9794. Reimbursement of Medical-Legal Expenses.

(a) The cost of comprehensive, follow-up and supplemental medical-legal evaluation reports, diagnostic tests, and medical-legal testimony, regardless of whether incurred on behalf of the employee or claims administrator, shall be billed and reimbursed as follows:

(1) X-rays, laboratory services and other diagnostic tests shall be billed and reimbursed in accordance with the official medical fee schedule adopted pursuant to Labor Code Section 5307.1. In no event shall the claims administrator be liable for the cost of any diagnostic test provided in connection with a comprehensive medical-legal evaluation report unless the subjective complaints and physical findings that warrant the necessity for the test are included in the medical-legal evaluation report. Additionally, the claims administrator shall not be liable for the cost of diagnostic tests, absent prior authorization by the claims administrator, if adequate medical information is already in the medical record provided to the physician.

(2) The cost of comprehensive, follow-up and supplemental medical-legal evaluations, and medical-legal testimony shall be billed and reimbursed in accordance with the schedule set forth in Section 9795.

(b) All medical-legal expenses shall be paid within 60 days after receipt by the employer of the reports and documents required by the administrative director unless the claims administrator, within this period, contests its liability for such payment.

(c) A claims administrator who contests all or any part of a bill for medical-legal expense, or who contests a bill on the basis that the expense does not constitute a medical-legal expense, shall pay any uncontested amount and notify the physician or other provider of the objection within sixty days after receipt of the reports and documents required by the administrative director. Any notice of objection shall include or be accompanied by all of the following:

(1) An explanation of the basis for the objection to each contested procedure and charge. The original procedure codes used by the physician or other provider shall not be altered. If the objection is based on appropriate coding of a procedure, the explanation shall include both the code reported by the provider and the code believed reasonable by the claims administrator, and shall include the claim's administrator's rationale as to why its code more accurately reflects the service provided. If the claims administrator denies liability for the entire medical-legal expense, the objection shall set forth the legal, medical or factual basis for the denial.

(2) If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the information required.

(3) The name, address, and telephone number of the person or office to contact for additional information concerning

the objection.

(4) A statement that the physician or other provider may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board.

A form objection which does not identify the specific deficiencies of the report in question shall not satisfy the requirements of this subdivision.

(d) All reports and documents required by the administrative director shall be included in or attached to the medical-legal report when it is filed and served on the parties pursuant to Section 10608 or served on the parties pursuant to Section 4061 or 4062 of the Labor Code.

(e) Physicians shall keep and maintain for three years, and shall make available to the administrative director by date of examination upon request, copies of all billings for medical-legal expense.

(f) A physician may not charge, nor be paid, any fees for services in violation of Section 139.3 of the Labor Code or subdivision (d) of Section 5307.6 of the Labor Code;

(g) Claims administrator shall retain, for three years, the following information for each comprehensive medical evaluation for which the claims administrator is billed:

(1) name and specialty of medical evaluator;

(2) name of the employee evaluated;

(3) date of examination;

(4) the amount billed for the evaluation;

(5) the date of the bill;

(6) the amount paid for the evaluation, including any penalties and interest;

(7) the date payment was made.

This information may be stored in paper or electronic form and shall be made available to the administrative director upon request. This information shall also be made available, upon request, to any party to a case, where the requested information pertains to an evaluation obtained in the case.

Note: Authority cited: Sections 133, 4627, 5307.3 and 5307.6, Labor Code. Reference: Sections 4620, 4621, 4622, 4625, 4626, 4628 and 5307.6, Labor Code.

HISTORY

1. Repealer and new section filed 8-3-93; operative 8-3-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 32).

2. Amendment of subsections (a)-(c)(1) and (e), and new subsections (f)-(h) filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

3. Repealer of subsection (h) filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

4. Editorial correction of subsection (a) (Register 2001, No. 22).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 5.6. Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations

New query

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§9795. Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony.

(a) The schedule of fees set forth in this section shall be prima facie evidence of the reasonableness of fees charged for medical-legal evaluation reports, and fees for medical-legal testimony.

Reports by treating or consulting physicians, other than comprehensive, follow-up or supplemental medical-legal evaluations, regardless of whether liability for the injury has been accepted at the time the treatment was provided or the report was prepared, shall be subject to the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1 rather than to the fee schedule set forth in this section.

(b) The fee for each evaluation is calculated by multiplying the relative value by $12.50, and adding any amount applicable because of the modifiers permitted under subdivision (d). The fee for each medical-legal evaluation procedure includes reimbursement for the history and physical examination, review of records, preparation of a medical-legal report, including typing and transcription services, and overhead expenses. The complexity of the evaluation is the dominant factor determining the appropriate level of service under this section; the times to perform procedures is expected to vary due to clinical circumstances, and is therefore not the controlling factor in determining the appropriate level of service.

(c) Medical-legal evaluation reports and medical-legal testimony shall be reimbursed as follows:

CODE	B.R.	PROCEDURE DESCRIPTION
ML100		Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation. This code is designed for communication purposes only. It does not imply that compensation is necessarily owed.
CODE	RV	PROCEDURE DESCRIPTION
ML101	5	Follow-up Medical-Legal Evaluation. Limited to a follow-up medical-legal evaluation by a physician which occurs within nine months of the date on which the prior medical-legal evaluation was performed. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face-to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour.
CODE	RV	PROCEDURE DESCRIPTION
ML102	50	Basic Comprehensive Medical-Legal Evaluation. Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.
CODE	RV	PROCEDURE DESCRIPTION
ML103	75	Complex Comprehensive Medical-Legal Evaluation. Includes evaluations which require three of the complexity factors set

forth below.
In a separate section at the beginning of the report, the psysician shall clearly and concisely specify which of the following complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon:
(1) Two or more hours of face-to-face time by the physician with the injured worker;
(2) Two or more hours of record review by the physician;
(3) Two or more hours of medical research by the physician;
(4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor;
(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors;
(6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report, or if a bona fide issue of medical causation is discovered in the evaluation;
(7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents ofGuides to the Evaluation of Permanent Impairment (Fifth Edition), or two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents ofGuides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.
(8) Addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances;
(9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.
(10) Addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.

CODE	RV	PROCEDURE DESCRIPTION
ML104	5	Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for any of the following: (1) An evaluation which requires four or more of the complexity factors listed under ML 103; In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon. (2) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician; (3) A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. When billing under this code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.

CODE	RV	PROCEDURE DESCRIPTION
ML105	5	Fees for medical-legal testimony. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by

		the physician. The physician shall be entitled to fees for all itemized reasonable and necessary time spent related to the testimony, including reasonable preparation and travel time. The physician shall be paid a minimum of one hour for a scheduled deposition.
CODE	RV	PROCEDURE DESCRIPTION
ML106	5	Fees for supplemental medical-legal evaluations. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. Fees will not be allowed under this section for supplemental reports following the physician's review of (A) information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing the initial report or (B) the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation.

(d) The services described by Procedure Codes ML101 through ML106 may be modified under the circumstances described in this subdivision. The modifying circumstances shall be identified by the addition of the appropriate modifier code, which is reported by a two-digit number placed after the usual procedure number separated by a hyphen. The modifiers available are the following:
-92 Performed by a primary treating physician. This modifier is added solely for identification purposes, and does not change the normal value of the service.

-93 Interpreter needed at time of examination, or other circumstances which impair communication between the physician and the injured worker and significantly increase the time needed to conduct the examination. Requires a description of the circumstance and the increased time required for the examination as a result. Where this modifier is applicable, the value for the procedure is modified by multiplying the normal value by 1.1. This modifier shall only be applicable to ML 102 and ML 103.

-94 Evaluation and medical-legal testimony performed by an Agreed Medical Evaluator. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.25. If modifier -93 is also applicable for an ML-102 or ML-103, then the value of the procedure is modified by multiplying the normal value by 1.35.

-95 Evaluation performed by a panel selected Qualified Medical Evaluator. This modifier is added solely for identification purposes, and does not change the normal value of any procedure.

(e) Requests for duplicate reports shall be in writing. Duplicate reports shall be separately reimbursable and shall be reimbursed in the same manner as set forth in the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1.

(f) This section shall apply to medical-legal evaluation reports where the examination occurs on or after the effective date of this section. The 2006 amendments to this section shall apply to: (1) medical-legal evaluation reports where the medical examination to which the report refers occurs on or after the effective date of the 2006 amendments; (2) medical-legal testimony provided on or after the effective date of the 2006 amendments; and (3) supplemental medical legal reports that are requested on or after the effective date of the 2006 amendments regardless of the date of the original examination.

Note: Authority cited: Sections 133, 4627, 5307.3 and 5307.6, Labor Code. Reference: Sections 139.2, 4061, 4061.5, 4062, 4620, 4621, 4622, 4625, 4626, 4628, 5307.6 and 5402, Labor Code.

HISTORY

1. Repealer and new section filed 8-3-93; operative 8-3-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 32).

2. Change without regulatory effect amending subsection (a) and subsection (c)medical-legal evaluation procedure code ML104 filed 8-27-93 pursuant to section 100, title 1, California Code of Regulations (Register 93, No.35).

3. Amendment of section heading, section and Notefiled 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section11351 (Register 93, No. 53).

4. Amendment filed 2-24-99; operative 4-1-99 (Register 99, No. 9).

5. Change without regulatory effect amending subsections (b) and (d) filed 6-12-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 24).

6. Amendment of section and Notefiled 6-30-2006; operative 7-1-2006. Submitted to OAL for filing with the Secretary of State and printing only pursuant to Government Code section 11340.9(g) (Register 2006, No. 26).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 5.7 Fees for Interpreter Services

New query

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§9795.1. Definitions.

As used in this article:

(a) "Certified" means an interpreter who is certified in accordance with subdivision (e) of Section 11513 of the Government Code or Section 68562 of the Government Code.

(b) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(c) "Full day" means services performed which exceed one-half day, up to 8 hours.

(d) "One-half day" means:

(1) When appearing at any Workers' Compensation Appeals Board hearing, daytime arbitration or formal rehabilitation conference, all or any part of a morning or afternoon session.

(2) When appearing at a deposition, all or any part of 3.5 hours.

(3) When appearing at an evening arbitration, all or any part of 3 hours.

(e) "Provisionally certified" means an interpreter who is deemed to be qualified to perform services under this article, when a certified interpreter cannot be present, by (A) the residing officer at an appeals board hearing, arbitration, or formal rehabilitation conference, at the request of a party or parties, or (B) agreement of the parties for any services provided under this article other than at an appeals board hearing, arbitration, or formal rehabilitation conference.

(f) "Qualified interpreter" means an interpreter who is certified or provisionally certified.

(g) "Travel time" means the time an interpreter actually travels to and from the place where service is to be rendered and his or her place of business.

(h) "Market rate" means that amount an interpreter has actually been paid for recent interpreter services provided in connection with the preparation and resolution of an employee's claim.

NOTE: Authority cited: Sections 133, 5307.3, 5710 and 5811, Labor Code. Reference: Sections 4600, 4620, 4621, 5710 and 5811, Labor Code; and Sections 11513 and 68562, Government Code.

HISTORY

1. New article 5.7 (sections 9795.1-9795.4) and section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

2. Repealer of subsection (g), subsection relettering, and new Note filed 12-30-96; operative 12-30-96 pursuant to Government Code section 11343.4(d). Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 97, No. 1).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 5.7 Fees for Interpreter Services

New query

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§9795.2. Notice of Right To Interpreter.

The notice of hearing, deposition, or other setting shall include a statement explaining the right to have an interpreter present if they do not proficiently speak or understand the English language. Where a party is designated to serve a notice, it shall be the responsibility of that party to include this statement in the notice.

NOTE: Authority cited: Sections 133, 5307.3, 5710 and 5811, Labor Code. Reference: Sections 4600, 4620, 4621, 5710 and 5811, Labor Code; and Sections 11513 and 68562, Government Code.

HISTORY

1. New section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

2. New Note filed 12-30-96; operative 12-30-96 pursuant to Government Code section 11343.4(d). Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 97, No. 1).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 5.7 Fees for Interpreter Services

New query

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§9795.3. Fees for Interpreter Services.

(a) Fees for services performed by a qualified interpreter, where the employee does not proficiently speak or understand the English language, shall be paid by the claims administrator for any of the following events:

(1) An examination by a physician to which an injured employee submits at the requests of the claims administrator, the administrative director, or the appeals board;

(2) A comprehensive medical-legal evaluation as defined in subdivision (c) of Section 9793, a follow-up medical-legal evaluation as defined in subdivision (f) of Section 9793, or a supplemental medical-legal evaluation as defined in subdivision (k) of Section 9793; provided, however, that payment for interpreter's fees by the claims administrator shall not be required under this paragraph unless the medical report to which the services apply is compensable in accordance with Article 5.6. Nothing in this paragraph, however, shall be construed to relieve the party who retains an interpreter from liability to pay the interpreter's fees in the event the claims administrator is not liable.

(3) A deposition of an injured employee or any person claiming benefits as a dependent of an injured employee, at the request of the claims administrator, including the following related events:

(i) Preparation of the deponent immediately prior to the deposition,

(ii) Reading of a deposition to a deponent prior to signing, and,

(iii) Reading of prior volumes to a deponent in preparation for continuation of a deposition.

(4) An appeals board hearing, arbitration, or formal rehabilitation conference.

(5) An informal rehabilitation conference.

(6) A conference held by an information and assistance officer pursuant to Chapter 2.5 (commencing with Section 5450) of Part 4 of Division 4 of the Labor Code to assist in resolving a dispute between an injured employee and a claims administrator.

(7) Other similar settings determined by the Workers' Compensation Appeals Board to be reasonable and necessary to determine the validity and extent of injury to an employee.

(b) The following fees for interpreter services provided by a certified interpreter shall be presumed to be reasonable:

(1) For an appeal board hearing, arbitration, deposition, or formal rehabilitation conference: interpreter fees shall be

billed and paid at the greater of the following (i) at the rate for one-half day or one full day as set forth in the Superior Court fee schedule for interpreters in the county where the service was provided, or (ii) at the market rate. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services. Services over 8 hours shall be paid at the rate of one-eighth the full day rate for each hour of service over 8 hours.

(2) For all other events listed under subdivision (a), interpreter fees shall be billed and paid at the rate of $11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter's services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.

(3) The fee in paragraph (1) or (2) shall include, when requested and adequately documented by the interpreter, payment for mileage and travel time where reasonable and necessary to provide the service, and where the distance between the interpreter's place of business and the place where the service was rendered is over 25 miles. Travel time is not deemed reasonable and necessary where a qualified interpreter listed in the master listing for the county where the service is to be provided can be present to provide the service without the necessity of excessive travel.

(i) Mileage shall be paid at the minimum rate adopted by the Director of the Department of Personnel Administration pursuant to Section 19820 of the Government Code for non-represented (excluded) employees at Title 2, CCR § 599.631(a).

(ii) Travel time shall be paid at the rate of $5.00 per quarter hour or portion thereof.

(c) Unless notified of a cancellation at least 24 hours prior to the time the service is to be provided, the interpreter shall be paid no less than the minimum fee.

(d) Nothing in this section shall preclude payment to an interpreter or agency for interpreting services based on an agreement made in advance of services between the interpreter or agency and the claims administrator, regardless of whether or not such payment is less than, or exceeds, the fees set forth in this section.

(e) The fees set forth in subdivision (b) shall be presumed reasonable for services provided by provisionally certified interpreters only if efforts to obtain a certified interpreter are documented and submitted to the claims administrator with the bill for services. Efforts to obtain a certified interpreter shall also be disclosed in any document based in whole or in part on information obtained through a provisionally certified interpreter.

NOTE: Authority cited: Sections 133, 5307.3, 5710 and 5811, Labor Code. Reference: Sections 4600, 4620, 4621, 5710 and 5811, Labor Code; and Sections 11513 and 68562, Government Code.

HISTORY

1. New section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

2. Amendment of subsections (b)(1) and (b)(2), repealer of subsection (b)(3), subsection renumbering, amendment of newly designated subsection (b)(4) and subsection (d), and new Note filed 12-30-96; operative 12-30-96 pursuant to Government Code section 11343.4(d). Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 97, No. 1).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 5.7 Fees for Interpreter Services

New query

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§9795.4. Time for Payment; Effective Date.

(a) All expenses for interpreter services shall be paid within 60 days after receipt by the claims administrator of the bill for services unless the claims administrator, within this period, contests its liability for such payment, or the reasonableness or the necessity of incurring such expenses. A claims administrator who contests all or any part of a bill for interpreter services shall pay the uncontested amount and notify the interpreter of the objection within 60 days after receipt of the bill. Any notice of objection shall include all of the following:

(1) An explanation of the basis of the objection.

(2) If additional information is needed as a prerequisite to payment of a contested bill or portions thereof, a clear description of the information required.

(3) The name, address and telephone number of the person or office to contact for additional information concerning the objection.

(4) A statement that the interpreter may adjudicate the issue of the contested charge before the Workers' Compensation Appeals Board.

(b) Any bill for interpreter's services which constitutes a medical-legal expense as defined in subdivision (g) of Section 9793 and which is neither paid nor contested within the time limits set forth herein shall be subject to the penalties and interest set forth in Section 4622 of the Labor Code.

(c) This article shall be effective for services provided on and after the effective date of this article which pertain to injuries occurring on or after January 1, 1994. Amendments to this article which became effective in 1996 shall apply to interpreting services provided on or after April 1, 1997.

NOTE: Authority cited: Sections 133, 5307.3, 5710 and 5811, Labor Code. Reference: Sections 4600, 4620, 4621, 5710 and 5811, Labor Code; and Sections 68562 and 11513, Government Code.

HISTORY

1. New section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

2. Amendment of subsection (c) and Note filed 12-30-96; operative 12-30-96 pursuant to Government Code section 11343.4(d). Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 97, No. 1).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 6. Consulting Physician, Certification Of

New query

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§9796. Certification of Consulting Physician, How Initiated.

When an injured employee requests an employer to secure certification of a consulting physician under Labor Code Section 4602, the employer shall direct a letter in triplicate to the Division of Industrial Accidents, attention Medical Director, 525 Golden Gate Avenue, Room 201, San Francisco, California 94102, containing the following information:

(a) The name and address of the injured employee;

(b) The name and address of the consulting physician chosen;

(c) The field of practice of the consulting physician.

NOTE: Authority cited: Sections 124, 127, 133, 138.2, 138.3, 138.4, 139, 139.5, 139.6, 4600, 4601, 4602, 4603, 4603.2, 4603.5, 5307.3, 5450, 5451, 5452, 5453, 5454, and 5455, Labor Code. Reference: Chapters 442, 709, and 1172, Statutes of 1977; Chapter 1017, Statutes of 1976.

HISTORY

1. Amendment filed 11-7-78; effective thirtieth day thereafter (Register 78, No. 45).

2. Change without regulatory effect filed 7-11-86; effective upon filing (Register 86, No. 28).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 6. Consulting Physician, Certification Of

New query

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§9799. Criterion for Certifying Competence.

The criterion to be followed by the Administrative Director in certifying the competence of the consulting physician chosen by the injured employee is that the field of practice is related to the injury or the problem for which consultation was requested.

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 6. Consulting Physician, Certification Of

New query

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§9802. Notification by Administrative Director.

The Administrative Director will notify the employer and employee as to the competence of a consulting physician within twelve (12) days of the date of the receipt of the request for such certification.

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 7. Schedule for Rating Permanent Disabilities

New query

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§9805. Schedule for Rating Permanent Disabilities, Adoption, Amendment.

The method for the determination of percentages of permanent disability is set forth in the Schedule for Rating Permanent Disabilities, which has been adopted by the Administrative Director effective January 1, 2005, and which is hereby incorporated by reference in its entirety as though it were set forth below. The schedule adopts and incorporates the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment 5th Edition. The schedule shall be effective for dates of injury on or after January 1, 2005 and for dates of injury prior to January 1, 2005, in accordance with subdivision (d) of Labor Code section 4660, and it shall be amended at least once every five years.

The schedule may be downloaded from the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/dwcrep.htm.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. Amendment filed 12-8-69; designated effective 1-1-70 (Register 69, No. 50).

2. Amendment filed 12-14-72; designated effective 1-1-73 (Register 72, No. 51).

3. Editorial correction (Register 81, No. 31).

4. Amendment filed 7-15-83; effective thirtieth day thereafter (Register 83, No. 30).

5. Editorial correction of 7-15-83 order redesignating effective date to 8-1-83 pursuant to Government Code Section 11346.2(d) filed 7-19-83 (Register 83, No. 30).

6. Amendment of section and Note filed 12-31-2004 as an emergency; operative 1-1-2005 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 5-2-2005 or emergency language will be repealed by operation of law on the following day.

7. Certificate of Compliance as to 12-31-2004 order, including further amendment of section, transmitted to OAL 4-29-2005 and filed 6-10-2005 (Register 2005, No. 23).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 7. Schedule for Rating Permanent Disabilities

New query

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§9805.1. Data Collection, Evaluation, and Revision of Schedule.

The Administrative Director shall: (1) collect for 18 months permanent disability ratings under the 2005 Permanent Disability Rating Schedule (PDRS) effective for injuries occurring on or after 1/1/05 and effective for injuries occurring on or after 4/19/04 and before 1/1/05 where there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notice required by Labor Code Section 4601 to the injured employee; (2) evaluate the data to determine the aggregate effect of the diminished future earning capacity adjustment on the permanent partial disability ratings under the 2005 PDRS; and (3) revise, if necessary, the diminished future earning capacity adjustment to reflect consideration of an employee's diminished future earning capacity for injuries based on the data collected. If the Administrative Director determines that there is not a sufficient amount of data to perform a statistically valid evaluation, the Administrative Director shall continue to collect data until a valid statistical sample is obtained. If there is a statistically valid sample of data that the Administrative Director determines supports a revision to the diminished future earning capacity adjustment, the Administrative Director shall revise the PDRS before the mandatory five year statutory revision contained in Labor Code section 4660(c).

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4660, 4662, 4663 and 4664, Labor Code.

HISTORY

1. New section filed 6-10-2005; operative 6-10-2005 (Register 2005, No. 23).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 8. Benefit Notices; Claims Administrator's Duties and Responsibilities; Claim Form and Notice of Potential Eligibility for Benefits; Regulatory Authority of the Administrative Director.

New query

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§9810. General Provisions.

(a) This Article applies to benefit notices prepared on or after its effective date. Amendments to this Article filed with the Secretary of State on December 11, 2007 shall become effective for notices required to be sent on or after April 9, 2008.

(b) The Administrative Director may issue and revise from time to time a Benefit Notice Instruction Manual as a guide for completing and serving the notices required by this Article.

(c) Benefit notice letters, excepting those notices whose language or format are set forth in statute or where a specific notice form has been adopted as a regulation, may be produced on the claims administrator's letterhead. Unless sent on the claims administrator's letterhead, all notice letters shall identify the claims administrator's name, mailing address and telephone number, the employee's name, employer's name, the claim number, the date the notice was sent to the employee, and the date of injury. All notices shall clearly identify the name and telephone number and mailing address of the individual claims examiner responsible for the payment and adjusting of the claim, and shall include a notation if one or more attachments are being sent with the notice and shall clearly state that additional information may be obtained from an Information and Assistance officer with the Division of Workers' Compensation. If the employer offers additional disability benefits in addition to those provided by law under workers' compensation, the claims administrator may incorporate the information within the notices required by these regulations. A single benefit notice may encompass multiple events.

(d) Benefit notices, excepting those notices whose language or format are set forth in statute or specific notice forms adopted by regulation, may be produced in any format developed by the claims administrator. Each such benefit notice shall contain all relevant notice elements required by either statute or regulation. The Administrative Director shall make sample notices that comply with these requirements available on the DWC website.

(e) The claims administrator shall provide copies to the employee, upon request, of all medical reports, relevant to any benefit notice issued, or which are not required to be provided along with a notice and have not yet been provided to the employee other than psychiatric reports which the physician has recommended not be provided to the employee.

(f) The claims administrator shall send a copy of each benefit notice, and any enclosures not previously served on the attorney, concurrently to the attorney of any represented employee.

(g) Any deadline for reply which is measured from the date a notice is sent, and all rights protected within the deadline, are extended if the notice is sent by mail, as follows: by 5 days if the place of mailing and the place of address are in the same state of the United States; by 10 days if the place of mailing and the place of address are in

different states of the United States; by 20 days if the place of mailing is in and the place of address is outside the United States. All notices shall be mailed from the United States.

(h) Copies of all benefit notices sent to injured workers shall be maintained by the claims administrator in the claims file. In lieu of retaining a copy of any attachments to the notice, the claims administrator may identify the attachments by name and revision date on the notice. These copies may be maintained in paper or electronic form.

(i) All benefit notices shall be made available in English and Spanish, as appropriate.

Note: Authority cited: Sections 59, 124, 133, 138.3, 138.4, 139.5(a)(2), 4061(a), (b), (d) and 5307.3, Labor Code. Reference: Sections 138.4, 139.5(a)(3), 4061 and 4650(a)-(d), Labor Code.

HISTORY

1. Repealer of article 8 (sections 9810-9878, not consecutive) and new article 8 (sections 9810-9817) filed 7-15-83; effective thirtieth day thereafter (Register 83, No. 30). For prior history, see Registers 81, No. 42; 79, No. 30; 78, No. 45; 73, Nos. 51 and 38; 72, No. 51; and 66, No. 20.

2. Editorial correction of 7-15-83 order redesignating effective date to 8-1-83 pursuant to Government Code section 11346.2(d) filed 7-19-83 (Register 83, No. 30).

3. Editorial correction of 7-15-83 order filed 8-11-83 (Register 83, No.33).

4. Amendment of article heading, section and Notefiled 1-7-94; operative 1-7-94. Submitted to OAL for printing only pursuant to Government Code section11351 (Register 94, No. 1).

5. Repealer of subsection (d) and subsection relettering filed 7-7-2004; operative 8-1-2004 pursuant to Government Code section 11343.4 (Register 2004, No. 28).

6. Repealer and new article heading and amendment of section andNote filed 12-11-2007; operative 4-9-2008 (Register 2007, No. 50).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 8. Benefit Notices; Claims Administrator's Duties and Responsibilities; Claim Form and Notice of Potential Eligibility for Benefits; Regulatory Authority of the Administrative Director.

New query

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§9811. Definitions.

As used in this Article:

(a) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, a self-administered joint powers authority, a self-administered legally uninsured, a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority, or an administrator for an alternative dispute resolution (ADR) program established under Labor Code section 3201.5 or 3201.7.

(b) "Date of knowledge of injury" means the date the employer had knowledge of a worker's injury or claim of injury.

(c) "Date of knowledge of injury and disability" means the date the employer had knowledge of (1) a worker's injury or claim of injury, and (2) the worker's inability or claimed inability to work because of the injury.

(d) "Duration" means any known period of time for which benefits are to be paid, or, where benefits will continue for an unknown period of time the event that will occur which will determine when benefits will terminate.

(e) "Employee" includes dependent(s) in the event of any injury which results in death.

(f) "Employee's (or claimant's) remedies", means a statement of the employee's rights of which an employee or claimant shall be informed in benefit notices when specified in these regulations.

Every benefit notice, excepting those mandatory notices set forth in statute or where a specific notice form has been adopted as a regulation, shall include a mandatory statement of employee's (or claimant's) remedies:

For claims not falling under an alternative dispute resolution program (ADR) program under Labor Code sections 3201.5 or 3201.7, the following language shall be used:

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (insert adjuster's name and telephone number). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (insert local I&A number).

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

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

To resolve a dispute, you may apply to [choose appropriate option(s)] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

For employees subject to an ADR program under Labor Code sections 3201.5 or 3201.7, the claims administrator may substitute the following language where appropriate:

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (insert adjuster's name and telephone number) or, (insert name of ombudsperson or mediator if employee is subject to an ADR agreement). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster, ombudsperson or mediator. If you want further information on your rights to benefits or disagree with our decision, you may also contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (insert local I&A number). Please be sure to inform the Information and Assistance Officer that you are subject to an alternative dispute resolution program.

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

NOTE: For employees subject to an ADR program under Labor Code section 3201.5, the claims administrator may include the following language if appropriate under the provisions of the ADR program:

In accordance with the (insert union name) agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. Your right to obtain legal advice is not limited and you may obtain such at your own expense at anytime. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.

(g) "Employer" means any person or entity defined as an employer by Labor Code Section 3300.

(h) "Injury" means any injury as defined in Labor Code Section 3208 which results in medical treatment beyond first aid, lost time beyond the date of injury, or death.

(i) "Permanent and stationary status," means the point when the employee has reached maximal medical improvement his or her condition is well stabilized and unlikely to change substantially in the next year with or without medical treatment.

Note: Authority cited: Sections 59, 133, 138.3, 138.4 and 5307.3, Labor Code. Reference: Sections 138.4, 139.5(c), (d), 3201.5, 3201.7, 3208, 3300, 3351, 3351.5, 3700, 3753, 4635(a), 4650(a)-(d), 4653, 4654, 4700 and 4701, Labor Code; Sections 11651 and 11652, Insurance Code; Sections 2330 and 2332, Civil Code.

HISTORY

1. Amendment of section and Notefiled 1-7-94; operative 1-7-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 1).

2. Amendment of section andNote filed 12-11-2007; operative 4-9-2008 (Register 2007, No. 50).

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New query

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§9812. Benefit Payment and Notice.

(a) Temporary Disability Notices. When an injury causes or is claimed to cause temporary disability:

(1) Notice of First Temporary Disability Indemnity Payment. The first time the claims administrator pays temporary disability indemnity, the claims administrator shall advise the employee of the amount of temporary disability indemnity due, how it was calculated, and the duration and schedule of indemnity payments. The notice shall be sent no later than the 14th day after the employer's date of knowledge of injury and disability. A copy of the most recent version of the DWC informative pamphlet "Temporary Disability Fact Sheet' shall be provided with the notice.

(2) Notice of Delay in Any Temporary Disability Indemnity Payment. If the employee's entitlement to any period of temporary disability indemnity cannot be determined within 14 days of the date of knowledge of injury and disability, the claims administrator shall advise the employee within the 14-day period of the delay, the reasons for it, the need, if any, for additional information required to make a determination, and when a determination is likely to be made. If the claims administrator cannot make a determination by the date specified in a notice to the injured worker, the claims administrator shall send a subsequent delay notice to the injured worker, not later than the determination date specified in the previous delay notice, notifying the injured worker of the revised date by which the claims administrator now expects the determination to be made.

(A) Where the delay is related to a medical issue, the notice shall advise an unrepresented employee of one of the following options:
1. If the injured worker has already received a comprehensive medical evaluation and either party disputes the results of that evaluation, the injured worker may be asked to return to that physician for a new evaluation.

2. If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's temporary disability status and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

(B) Where the delay is related to a medical issue, the notice shall advise a represented employee of one of the following options:

1. For dates of injury from January 1, 1994 through December 31, 2004, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

2. For dates of injury on or after January 1, 2005, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.
A copy of the most recent version of the DWC informative pamphlet "QME/AME Fact Sheet" shall be provided with the notice.

The additional delay notices shall comply with all requirements for an original delay notice, except that no copy of the DWC informative pamphlet "QME/AME Fact Sheet" need be provided with the notice unless it has been revised since it was last provided.

(3) Notice of Denial of Any Temporary Disability Indemnity Payment. If the claims administrator denies liability for the payment of any period for which an employee claims temporary disability indemnity, the notice shall advise the employee of the denial and the reasons for it. The notice shall be sent within 14 days after the determination to deny was made.

(A) Where the denial is related to a medical issue, the notice shall advise an unrepresented employee of one of the following options:

1. If the denial is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.

2. If the injured worker has already received a comprehensive medical evaluation, and either party disputes the results of that evaluation, the injured worker may be asked to return to that physician for a new evaluation.

3. If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1.
The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's temporary disability status and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

(B) Where the denial is related to a medical issue, the notice shall advise a represented employee of one of the following options:

1. If the denial is based on a comprehensive medical evaluation, the injured worker may file an Application for

Adjudication of Claim with the WCAB.

2. For dates of injury from January 1, 1994 through December 31, 2004, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

3. For dates of injury on or after January 1, 2005 if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

A copy of the relevant DWC informative pamphlet(s) "TD Fact Sheet," "QME/AME Fact Sheet" and/or "Permanent Disability Fact Sheet" shall be provided at this time.

(b) Notice of Resumed Benefit Payments (TD, SC, PD, VRTD/VRMA). If the payment of temporary disability indemnity, salary continuation, permanent disability indemnity, or vocational rehabilitation temporary disability indemnity or maintenance allowance is resumed after terminating any of these benefits, the claims administrator shall advise the employee of the amount of indemnity due and the duration and schedule of payments. Notice shall be sent within 14 days after the employer's date of knowledge of the entitlement to additional benefits.

(c) Notice of Changed Benefit Rate, Payment Amount or Schedule (TD, SC, PD, VRTD/VRMA). When the claims administrator changes the benefit rate, payment amount or benefit payment schedule for temporary disability indemnity, salary continuation, permanent disability indemnity, or vocational rehabilitation temporary disability indemnity or maintenance allowance, the claims administrator shall advise the employee, as applicable, of the amount of the new benefit rate and the reason the rate is being changed, or of the new benefit payment schedule. Notice shall be given before or with the new payment.

(d) Notice that Benefits Are Ending (TD, SC, PD, VRTD/VRMA). With the last payment of temporary disability indemnity, permanent disability indemnity, salary continuation, or vocational rehabilitation temporary disability indemnity or maintenance allowance, the claims administrator shall advise the employee of the ending of indemnity payments and the reason, and shall make an accounting of all compensation paid to or on behalf of the employee in the species of benefit to which the notice refers, including the dates and amounts paid and any related penalties. If the decision to end payment of indemnity was made after the last payment, the claims administrator shall send the notice and accounting within 14 days of the last payment.

(1) The notice, except a notice that VRMA is ending, shall advise an unrepresented employee one of the following options:

(A) If the injured worker has already received a comprehensive medical evaluation, and either party disputes the results of that evaluation, the injured worker may be asked to return to that physician for a new evaluation.
(B) If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's temporary disability status or permanent impairment and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose

important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

(2) The notice, except a notice that VRMA is ending, shall advise a represented employee:

(A) If the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation.

(B) If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

A copy of the relevant DWC informative fact sheet pamphlet(s) "TD Fact Sheet," "QME/AME Fact Sheet" and/or "Permanent Disability Fact Sheet" shall be provided at this time.

(e) Permanent Disability Notices For Injuries That Occurred Prior To 1991:

(1) Existence and Extent of Permanent Disability is Known. Within 14 days after the claims administrator knows that the injury has caused permanent disability and knows the extent of that disability, the claims administrator shall advise the employee of the amount of the weekly permanent disability indemnity payment, how it was calculated, the duration and frequency of payments, the date payments can be expected to begin and the total amount to be paid.

(2) Existence of Permanent Disability is Known, Extent is Uncertain. If the claims administrator knows that the injury has caused permanent disability but cannot determine its extent within the 14 days after the last payment of temporary disability indemnity, or within 14 days after knowledge that the employee's injury has resulted in permanent disability if there was no compensable temporary disability, the claims administrator nevertheless shall make timely payment of permanent disability indemnity and shall advise the employee of the amount of the weekly permanent disability indemnity payment, how it was calculated, the duration and schedule of payments, and the claims administrator's reasonable estimate of the amount of permanent disability indemnity to be paid.

The claims administrator shall notify the employee that his or her medical condition will be monitored until the extent of permanent disability can be determined and that the disability payments will be revised at that time if appropriate. Within 14 days after the claims administrator determines the extent of permanent disability indemnity benefits, the claims administrator shall notify the employee as provided by paragraph (1).

(3) Existence of Permanent Disability is Uncertain. If the existence of permanent disability is uncertain, the claims administrator shall advise the employee within 14 days after the last payment of temporary disability indemnity, or within 14 days of receiving a claim or medical report alleging the existence of permanent disability if the claims administrator paid no temporary disability, that the claims administrator cannot yet determine whether the injury will cause permanent disability. The notice shall specify the reasons for the delay in determination, the need, if any, for additional information required to make a determination, and when the determination is likely to be made. If the claims administrator cannot make a determination by the date it specified in a notice to the injured worker, the claims administrator shall send a subsequent notice to the injured worker, not later than the determination date specified in the previous notice, notifying the injured worker of the date by which the claims administrator now expects the determination to be made. The additional delay notices shall comply with all requirements for an original delay notice. If the reason for the delay is that the employee's medical condition is not permanent and stationary, the claims administrator shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time an evaluation will be performed to determine the amount of permanent disability indemnity, if any, due the employee. Within 14 days after the claims administrator determines that permanent disability exists, the claims administrator shall notify the employee of the commencement of permanent disability indemnity payments as provided by paragraph (1) or (2).

(4) Notice That No Permanent Disability Exists. If the claims administrator alleges that the injury has caused no permanent disability, the claims administrator shall advise the employee within 14 days after the claims administrator determines that the injury has caused no permanent disability.

(f) Permanent Disability Notices for Injuries Occurring in 1991, 1992, 1993.

(1) Condition Not Permanent and Stationary (P & S), May Cause Permanent Disability -Notice of Monitoring Until P&S Date. If the injury has resulted or may result in permanent disability but the employee's medical condition is not permanent and stationary, the claims administrator shall advise the employee, together with the last payment of temporary disability indemnity, that permanent disability indemnity is or may be payable but that the amount cannot be determined because the employee's medical condition has not yet reached a stationary status. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time a medical evaluation will be performed to determine the existence and extent of permanent impairment or limitations and the need for continuing medical care. The notice shall advise the employee of the estimated date when a determination is likely to be made, and the claimant's remedies. If the claims administrator cannot make a determination of A) permanent and stationary status, B) the existence and extent of permanent impairment or limitations, and C) the need for continuing medical care by the date it specified in a monitoring notice to the injured worker, the claims administrator shall send a subsequent notice to the injured worker, not later than the determination date specified in the previous notice, notifying the injured worker of the date by which the claims administrator now expects the determination to be made. The additional notice shall comply with all requirements of the original delay notice.

(2) Condition Becomes Permanent and Stationary, May Cause Permanent Disability -Notice of Qualified Medical Evaluator (QME) Procedures. Within 5 working days after receiving information indicating that the employee's condition is permanent and stationary and has caused or may have caused permanent disability, the claims administrator shall advise the employee that his or her medical condition is permanent and stationary and of the procedures for evaluating permanent disability and need for continuing medical care.
(A) The notice shall advise an unrepresented employee of one of the following options:

1. If the injured worker has already received a comprehensive medical evaluation, and either party disputes the results of that evaluation, the injured worker may be asked to return to that physician for a new evaluation.

2. If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's permanent and stationary status and/or need for future medical care and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

(B) The notice shall advise a represented employee:

If the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

A copy of the most recent version of the DWC informative pamphlet "QME/AME Fact Sheet" shall be provided with the notice.

(3) Notice of Permanent Disability Indemnity Payment When Injury Causes Permanent Disability. If the claims administrator knows that the employee has sustained permanent disability, whether or not its extent is known and whether or not the employee's medical condition is permanent and stationary, the claims administrator shall advise the employee of the weekly permanent disability indemnity payment, how it was calculated, the duration and schedule of payments, and the claims administrator's reasonable estimate of permanent disability indemnity to be paid, within 14 days after knowledge that the employee's injury has resulted in permanent disability, whichever is later.

(A) The notice shall advise an unrepresented employee of one of the following options:

1. If the estimate is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.

2. If the injured worker has already received a comprehensive medical evaluation, and either party disputes the results of that evaluation, the injured worker may be asked to return to that physician for a new evaluation.

3. If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's permanent impairment and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

(B) The notice shall advise a represented employee of one of the following options:

1. If the determination is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.

2. If the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation.

3. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

(4) Notice That No Permanent Disability Exists. If the claims administrator alleges that the injury has caused no permanent disability, the claims administrator shall advise the employee that no permanent disability indemnity is payable. This notice shall be sent within 14 days after the claims administrator determines that the injury has caused no permanent disability. The notice shall advise the employee of the process to obtain a formal medical evaluation to contest the determination that the employee has no permanent disability. If the basis for the claims administrator's determination is a medical report, a copy of the most recent version of the DWC informative pamphlet "QME/AME Fact Sheet," shall be provided with the notice.

(A) The notice shall advise an unrepresented employee of one of the following options:

1. If the determination is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.

2. If the injured worker has already received a comprehensive medical evaluation, and either party disputes the results of that evaluation, the injured worker may be asked to return to that physician for a new evaluation.

3. If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's permanent impairment and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

(B) The notice shall advise a represented employee of one of the following options:

1. If the determination is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.

2. If the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

(g) Permanent Disability Notices For Injuries Occurring on or after 1/1/94. For injuries occurring on or after January 1, 1994:

(1) Condition Not Permanent and Stationary, May Cause Permanent Disability - Notice of Monitoring Until P&S Date. If the injury has resulted or may result in permanent disability but the employee's medical condition is not permanent and stationary, the claims administrator shall advise the employee together with the last payment of temporary disability indemnity, that permanent disability indemnity is or may be payable but that the amount cannot be determined because the employee's medical condition has not yet reached a stationary status. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time a medical evaluation will be performed to determine the existence and extent of permanent impairment or limitations and the need for continuing medical care. The notice shall advise the employee of the estimated date when a determination is likely to be made. If the claims administrator cannot make a determination of A) permanent and stationary status, B) the existence and extent of permanent impairment or limitations, and C) the need for continuing medical care by the date it specified in a monitoring notice to the injured worker, the claims administrator shall send a subsequent notice to the injured worker, not later than the determination date specified in the previous notice, notifying the injured worker of the date by which the claims administrator now expects the determination to be made. The additional notice shall comply with all requirements of the original notice.

(2) Condition Becomes Permanent and Stationary, Causes Permanent Disability - Notice of QME/AME Procedures. Together with the last payment of temporary disability or within 14 days of knowledge that the injury is permanent and stationary or has caused permanent disability, the claims administrator shall provide notice of the procedures available to obtain a QME or AME evaluation. The claims administrator shall advise the employee of the claims administrator's estimate of the amount of permanent disability indemnity payable, the basis for the estimate, and whether there is need for continuing medical care. A copy of the medical report on which the estimate of permanent disability was based, and a copy of the most recent version of the DWC informative pamphlets, QME/AME Fact Sheet and/or Permanent Disability Fact Sheet, shall be provided with the notice.

(A) The notice shall advise an unrepresented employee of one of the following options:

1. If the injured worker has already received a comprehensive medical evaluation, and either party disputes the results of that evaluation, the injured worker may be asked to return to that physician for a new evaluation.

2. If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1.

The notice shall include the claims administrator's decision on whether the claims administrator accepts or refutes the treating physician's evaluation of the employee's permanent impairment and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font at the top of the first page: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.

(B) If the claims administrator is not requesting a rating from the Disability Evaluation Unit, the notice shall also advise the worker that he or she may contact an Information and Assistance Officer to have the treating physician's evaluation reviewed and rated by the Disability Evaluation Unit.

(C) If the claims administrator has or will be requesting a rating from the Disability Evaluation Unit on the treating physician's evaluation, the notice shall advise the employee that he or she will be receiving a rating based on the treating physician's evaluation from the Disability Evaluation Unit.

(D) The notice shall advise a represented employee of one of the following options:

1. For dates of injury from January 1, 1994 through December 31, 2004, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

2. For dates of injury on or after January 1, 2005 if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

(3) Notice That No Permanent Disability Exists. If the claims administrator alleges that the injury has caused no permanent disability, the claims administrator shall advise the employee that no permanent disability indemnity is payable. This notice shall be sent together with the last payment of temporary disability indemnity or within 14 days after the claims administrator determines that the injury has caused no permanent disability. A copy of the medical report on which the determination of no permanent disability was based, and a copy of the most recent version of the DWC informative pamphlets, QME/AME Fact Sheet and Permanent Disability Fact Sheet shall be provided with the notice. A copy of the DWC form prescribed by the Administrative Director for requesting assignment of a panel of Qualified Medical Evaluators shall be provided with the notice unless the employee is represented by an attorney.

(A) The notice shall advise an unrepresented employee of one of the following options:
1. If the determination is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.

2. If the injured worker has already received a comprehensive medical evaluation, and either party disputes the results of that evaluation, the injured worker may be asked to return to that physician for a new evaluation.

3. If no comprehensive medical evaluation has taken place, the injured worker may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.1. The notice shall also advise of the procedure for requesting the panel and shall be accompanied by the form prescribed by the DWC Medical Unit with which to request assignment of a panel of Qualified Medical Evaluators. The notice shall advise the injured worker of the 10 day time limit in which a panel may be requested and in which an appointment must be made following receipt of the panel.

The notice shall contain the following warning in not less than 12 point font: You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully.
(B) If the denial is based upon the treating physician's report, the notice shall also advise the worker that he or she may contact an Information and Assistance office to have the treating physician's evaluation review and rated by the Disability Evaluation Unit.

(C) If the claims administrator requests a rating from the Disability Evaluation Unit on the treating physician's report, the notice shall advise the employee that he or she will be receiving a rating based on the treating physician's evaluation from the Disability Evaluation Unit.

(D) The notice shall advise a represented employee of one of the following options:

1. If the determination is based on a comprehensive medical evaluation, the injured worker may file an Application for Adjudication of Claim with the WCAB.

2. For dates of injury from January 1, 1994 through December 31, 2004, if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

3. For dates of injury on or after January 1, 2005 if the injured worker has already received a comprehensive medical evaluation, he or she may be asked to return to that physician for a new evaluation. If no comprehensive medical evaluation has taken place, an evaluation may be obtained from an Agreed Medical Evaluator if the parties agree or, if no agreement on an Agreed Medical Evaluator can be reached, the injured worker may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit pursuant to Labor Code section 4062.2 and that arrangements for obtaining this evaluation should be discussed with the injured worker's attorney.

(4) Notice of Permanent Disability Indemnity Payment When Injury Causes Permanent Disability. If the claims administrator knows that the employee has sustained permanent disability, whether or not its extent is known and whether or not the employee's medical condition is permanent and stationary, the claims administrator shall advise the employee of the weekly permanent disability indemnity payment, how it was calculated, the duration and schedule of payments, and the claims administrator's reasonable estimate of permanent disability indemnity to be paid, within 14 days after the last payment of temporary disability indemnity, or within 14 days after knowledge that the employee's injury has resulted in permanent disability, whichever is later. A copy of the most recent version of the DWC informative pamphlet "Permanent Disability Fact Sheet," shall be provided with the notice.

For injuries occurring on or after January 1, 2005, the claims administrator shall, concurrently with any increased or decreased payment, notify the injured worker of any increase or decrease in the amount of the injured worker's permanent disability payments, pursuant to Labor Code section 4658, subdivision (d) resulting from the employer's offer of regular, modified or alternative work or resulting from the employer's failure to offer, or the employer's early termination of, regular, modified or alternative work. The information required by this subdivision shall be given in the appropriate PD payment start notice, PD payment resumption notice or notice of change in rate, payment amount or

payment schedule.

(h) Notices to Dependents in Death Cases. In a case of fatal injury which is or is claimed to be compensable under the workers' compensation laws of this state, or involving accrued compensation which was not paid to an injured employee before the employee's death, the claims administrator shall advise the dependent(s) of the status of any benefits to which they may be entitled or which they have claimed as a result of the employee's death. As used in this subsection, "dependent" includes any person who may be or has claimed to be entitled to workers' compensation benefits as the result of an employee's death (including compensation which was accrued and unpaid to an injured worker before his or her death), and also includes the parent or legal guardian of minor dependent children. The claims administrator shall send each dependent a copy of all notices concerning benefits claimed by, or which may be payable to, that dependent, including notices sent to a different dependent if the benefits paid to the different dependent affect the amount payable to the other claimant. If the claims administrator discovers a new dependent after having sent a notice, the claims administrator shall send copies of each prior notice which concerned benefits to which the newly-discovered dependent might be entitled, to that dependent.

(1) Benefit Payment Schedule. If the claims administrator pays death benefits (including compensation which was accrued and unpaid to an injured worker before his or her death), the claims administrator shall advise each affected dependent of the amount of the death benefit payable to the dependent, how it was calculated, the duration and schedule of payments and other pertinent information. Notice is required within 14 days after the claims administrator's date of knowledge both of the death and of the identity and address of the dependent.

(2) Notice of Changed Benefit Rate, Amount or Schedule or that Benefits are Ending. If the claims administrator changes the benefit rate, amount or payment schedule, or ends payment, of a death benefit to a dependent, the claims administrator shall advise the affected dependent of the change and the reason for it, or of the new payment schedule. A notice that benefits are ending shall include an accounting of all compensation paid to the claimant. A notice that payment is ending shall be sent with the last payment unless the decision to end payment was made after that payment; in that case it shall be sent within 14 days of the last payment. Other notices concerning changed payments shall be sent before or with the changed payment, but not later than 14 days after the last payment which was made before the change.

(3) Delay in Determining Benefits. If the claims administrator cannot determine entitlement to some or all death benefits, the claims administrator shall advise each affected dependent of the delay, the reasons for it, the need, if any, for additional information required to make a determination, and when a determination is likely to be made. Notice is required within 14 days after the claims administrator's date of knowledge of the death, the identity and address of the affected dependent, and the nature of the benefit claimed or which might be due. If the claims administrator cannot make a determination by the date it specified in a notice to the affected dependent(s), the claims administrator shall send a subsequent notice to the affected dependent(s), not later than the determination date specified in the previous notice, notifying the affected dependent(s) of the date by which the claims administrator now expects the determination to be made. The additional delay notices shall include the employee's remedies and shall comply with all requirements for an original delay notice.

(4) Notices Denying Death Benefits. If the claims administrator denies liability for the payment of any or all death benefits, the claims administrator shall advise the affected dependent(s) of the denial and the reasons for it. The notice shall be sent within 14 days after the determination to deny was made.

(i) Notice Denying Liability for All Compensation Benefits. If the claims administrator denies liability for the payment of all workers' compensation benefits for any claim except a claim for death benefits, including medical-only claims, the claims administrator shall advise the employee of the denial and the reasons for it. The notice shall be sent no later than 14 days after the determination to deny was made. A copy of the most recent version of the DWC informative pamphlet "QME/AME Fact Sheet" shall be provided with the notice.

For claims reported on or after April 19, 2004, if an injured worker has filed a completed claim form with the employer, the claims administrator shall advise the injured worker to send for consideration of payment, all bills for medical services provided between the date the completed claim form was given to the employer and the date that

liability for the claim is rejected, unless he or she has done so already. The claims administrator shall also advise the employee that the maximum payment for medical services that were provided consistent with the applicable treatment guidelines is $10,000.

A copy of the Notice Denying Liability for All Compensation Benefits shall be served on all lien claimants or all persons or entities who can reasonably be identified by the claims administrator from information in the claims file to be potential lien claimants on account of their having furnished benefits, goods or services for which a lien may be filed under Labor Code sections 4903 through 4906, inclusive.

(j) Notice of Delay in Determining All Liability. If the claims administrator cannot determine whether the employer has any liability for an injury, other than an injury causing death, within 14 days of the date of knowledge of injury, the claims administrator shall advise the employee within the 14-day period of the delay, the reasons for it, the need, if any, for additional information required to make a determination, and when a determination is likely to be made. If the claims administrator cannot make a determination by the date it specified in a notice to the injured worker, the claims administrator shall send a subsequent notice to the injured worker, not later than the determination date specified in the previous notice, notifying the injured worker of the date by which the claims administrator now expects the determination to be made. The additional delay notices shall comply with all requirements for an original delay notice. Where the delay is related to a medical issue, a copy of the most recent version of the DWC informative pamphlet "QME/AME Fact Sheet" shall be provided with the notice.

(1) For injuries on or after January 1, 1990, if the claims administrator sends a notice of a delay in its decision whether to accept or deny liability for the claim, the notice shall include an explanation that the claim is presumed to be compensable if not denied within 90 days from the filing of the claim form, and that this presumption can be rebutted only with evidence discovered after the 90-day period.

(2) For claims reported on or after April 19, 2004, regardless of the date of injury, if the claims administrator sends a notice of delay in its decision whether to accept or deny liability for the claim, the notice shall include an explanation that Labor Code section 5402(c), provides that within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treatment guidelines, for the alleged injury and shall continue to provide treatment until the date that liability is rejected. The notice shall advise the injured worker that the employer's liability for medical treatment under this Labor Code section is limited to ten thousand dollars ($10,000).

Note: Authority cited: Sections 59, 133, 138.3, 138.4, 139.5(a)(2), 4636(d), 4637 and 5307.3, Labor Code. Reference: Sections 138.4, 139.5, 4061(a), (b), 4061(d), 4061(e), 4061(f), 4062.1, 4650(a)-(d), 4658(d), 4661.5, 4700, 4701, 4702, 4703, 4703.5, 4903-4906 and 5402, Labor Code.

HISTORY

1. Repealer and new section filed 7-11-89; operative 10-1-89 (Register 89 No. 28).

2. Amendment of section and Note filed 1-7-94; operative 1-7-94. Submitted to
OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 1).

3. Amendment of section and Note filed 12-11-2007; operative 4-9-2008 (Register 2007, No. 50).

4. Change without regulatory effect amending subsection (g)(2) filed 12-9-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 50).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 8. Benefit Notices; Claims Administrator's Duties and Responsibilities; Claim Form and Notice of Potential Eligibility for Benefits; Regulatory Authority of the Administrative Director.

New query

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§9813. Vocational Rehabilitation Notices.

(a) The following notices are applicable to dates of injury through December 31, 2003. This section shall not apply to dates of injury on or after January 1, 2004.

(1) Notice of First Payment. The first time the claims administrator pays vocational rehabilitation temporary disability or maintenance allowance, the claims administrator shall advise the employee of the amount of indemnity due, how it was calculated, and the duration and schedule of indemnity payments. The notice is due by the 14th day after the employee requested vocational rehabilitation services. The notice shall include, if applicable, the employee's option to add an amount from permanent disability benefits to increase the maintenance allowance payments to the temporary disability rate.

(2) Delay in Providing Vocational Rehabilitation. If upon receipt of a medical report which indicates that an employee is likely to be precluded from his or her usual and customary occupation, or upon receipt of a request for vocational rehabilitation services the claims administrator cannot determine the employee's entitlement to vocational rehabilitation services, a notice of delay shall be sent. The notice shall be sent no later than 10 days from the date of receipt of the medical report or no later than 10 days from receipt of the employee's request for services.

The delay notice shall explain the reason for delay, the need, if any, for additional information required to make a determination and the date by which a determination is likely to be made. If the claims administrator cannot make a determination by the date it specified in a notice to the injured worker, the claims administrator shall send a subsequent notice to the injured worker, not later than the determination date specified in the previous notice, notifying the injured worker of the date by which the claims administrator now expects the determination to be made. The additional delay notices shall include the employee's remedies and shall comply with all requirements for an original delay notice.

(3) Denial of Vocational Rehabilitation Benefits. The claims administrator shall advise the employee of its determination that an employee is not a qualified injured worker, the reasons for it, enclosed a copy of the document in which the determination is based and the employee's remedies. The notice shall include a DWC Form RU 103 Request for Dispute Resolution. The notice is due within 10 days of either:

(A) A request for vocational rehabilitation services; or

(B) Receipt of a treating physician's final report determining medical eligibility subsequent to 90 days of aggregate total temporary disability; or

(c) Receipt of the document upon which the claims administrator relied for its determination.

If the claims administrator denies liability for rehabilitation services but remains liable for paying VRTD or VRMA benefits, the notice shall explain the distinction between the terminated and continuing rehabilitation benefits.

If the denial is on the basis that the employee is not medically eligible, a copy of the most recent version of the DWC informative pamphlet "QME/AME Fact Sheet" shall be provided to the employee.

(4) Interruption or Deferral of Vocational Rehabilitation Services. Within 10 days after agreeing to interrupt or defer vocational rehabilitation services, the claims administrator shall advise the employee of the interruption and the dates it will be in effect. The claims administrator shall send a like notice within 10 days after agreeing to a new or extended period of interruption. The notice shall include an explanation of the specific steps he or she must take to notify the claims administrator that he or she is ready to resume participation (e.g., written or telephonic communication to the claims administrator, the agreed Qualified Rehabilitation Representative or the employee's representative), and information regarding the likely termination of the employee's rights to vocational rehabilitation should the employee fail to request services within 5 years from the date of injury.

If the parties agree to an interruption or deferral which extends beyond the statutory period, the notice shall advise the employee that failure to request services within the agreed upon time frame is likely to terminate the employee's rights to rehabilitation services.

For injuries occurring on or after 1/1/94 where an interruption occurs during a vocational rehabilitation plan, the notice shall explain that the plan must by law be completed within 18 months of approval.

(b) Vocational Rehabilitation Notices for Injuries Occurring Prior to 1990.

(1) Potential Eligibility for Rehabilitation. Within 10 days of receipt of a physician's report or knowledge of a physician's opinion indicating that an employee may be permanently precluded from his or her usual and customary occupation or the position in which he or she was engaged at the time of injury, or if the employee has been totally temporarily disabled for an aggregate of 180 days, the claims administrator shall notify the employee within 10 days of the 180th day of his or her potential eligibility for vocational rehabilitation services. The notice shall include all of the following information:

(A) An explanation of the vocational rehabilitation services and rehabilitation temporary disability benefits available to the employee;

(B) Instructions how the employee may apply for vocational rehabilitation (e.g., by written or telephonic communication to the claims administrator, the agreed Qualified Rehabilitation Representative or the employee's

representative);

(C) Notice of the employee's right to participate in selecting an agreed rehabilitation counselor;

(D) Notice that vocational rehabilitation benefits may not be settled or otherwise converted to cash payments;

(E) Either an offer of vocational rehabilitation services, or notice of delay or denial notice in accordance with Section 9813(a)(2) or (3).

(c) Vocational Rehabilitation Notices for Injuries Occurring in 1990, 1991, 1992 or 1993.

(1) At 90 days of Aggregate Temporary Disability Benefits. The claims administrator shall notify the worker no later than 10 days after an employee has accrued 90 days of aggregate temporary total disability benefits of the assignment of the Qualified Rehabilitation Representative (QRR) for the purpose of explaining the employee's potential entitlement to vocational rehabilitation services. The notice shall include a statement that the QRR will be assisting the employee in the development of a job description to submit to the treating physician for an opinion regarding whether the employee may be released to his or her usual and customary occupation. The notice shall further state that the employee will be notified of the physician's opinion when available.

(2) Potential Eligibility for Rehabilitation. Within 10 days of receipt of a physician's report or knowledge of a physician's opinion indicating that an employee is medically eligible for vocational rehabilitation, or if prior notice has not been sent, within 10 days after the employee has been totally temporarily disabled for an aggregate of more than 365 days, the claims administrator shall notify the employee of his or her potential eligibility for vocational rehabilitation services. The notice shall include the following information:

(A) The "Help in Returning to Work" pamphlet published by the Division of Workers' Compensation;

(B) If the notice contains an offer of services, the notice shall include instructions on how to apply for vocational rehabilitation services (e.g., by written or telephonic communication to the claims administrator, the agreed Qualified Rehabilitation Representative or the employee's representative);

(C) If the notice contains an offer of services, the notice shall state that failure to apply within 90 days of receipt of this notice may terminate the employee's entitlement to vocational rehabilitation services;

(D) If the notice contains an offer of services, information on the employee's right to assist in the selection of an agreed upon Qualified Rehabilitation Representative;

(E) If the notice contains an offer of services, advice that the employee may request an evaluation of his or her ability to benefit from the provision of services prior to accepting or rejecting vocational rehabilitation services;

(F) The notice may include a statement from the claims administrator that every effort will be made to identify a modified or alternate job with the same employer to speed the employee's return to the labor market.

(G) Either an offer of vocational rehabilitation services, or a delay or denial notice in accordance with Section

9813(a)(2) or (3) of these regulations.

(3) Reminder of Potential Eligibility. If the employee has not requested vocational rehabilitation services after notification of medical eligibility, the claims administrator shall remind the employee of his or her right to vocational rehabilitation services. The notice shall be made not earlier than 45 nor later than 70 days after the employee's receipt of the Notice of Potential Eligibility.

(4) Intention to Withhold Maintenance Allowance for Failure to Cooperate. If the employee unreasonably fails to cooperate in the provision of vocational rehabilitation services, the claims administrator shall give the employee written notice of any intention to withhold payment of vocational rehabilitation maintenance allowance, the reasons, and the employee's right to object within 10 days of receiving the notice. The notice shall be made at least 15 days before ending payment of vocational rehabilitation maintenance allowance. The notice shall include a DWC Form RU 103 "Request for Dispute Resolution".

(d) Vocational Rehabilitation Notices for Injuries Occurring on or after January 1, 1994 and before January 1, 2004.

(1) At 90 days of Aggregate Temporary Disability Benefits. The claims administrator shall notify the employee no later than 10 days after the employee accrues 90 days of aggregate temporary total disability benefits of the employee's potential rights to vocational rehabilitation. The notice shall include the "Help in Returning to Work" pamphlet as set forth in section 10133.2 of these regulations;

(2) Potential Eligibility for Rehabilitation. Within 10 days of receipt of a physician's report or knowledge of a physician's opinion indicating that an employee is medically eligible for vocational rehabilitation, or if prior notice has not been sent within 10 days after the employee has been totally temporarily disabled for an aggregate of 365 days, the claims administrator shall notify the employee of his or her potential eligibility for vocational rehabilitation services. The notice shall indicate the following information:

(A) The "Help in Returning to Work" pamphlet as set forth in section 10133.2 of these regulations;

(B) If the notice contains an offer of services, the notice shall include instructions on how to apply for vocational rehabilitation services (e.g., by written or telephonic communication to the claims administrator, the agreed Qualified Rehabilitation Representative or the employee's representative);

(C) If the notice contains an offer of services, the notice shall state that failure to apply within 90 days of receipt of this notice may terminate the employee's entitlement to vocational rehabilitation services;

(D) If the notice contains an offer of services, information on the employee's right to assist in the selection of an agreed upon Qualified Rehabilitation Representative;

(E) If the notice contains an offer of services, advice that the employee may request an evaluation of their ability to benefit from the provision of services prior to accepting or rejecting vocational rehabilitation services. The employee must further be advised that fees for such an evaluation are included within the forty-five hundred dollars ($4,500) maximum fees available for counseling services.

(F) The notice shall include a statement from the claims administrator whether a modified or alternate job with the employer is available. In the event that additional investigation into the availability of alternate or modified work is required, a final notice regarding the availability of modified or alternate work shall be sent within 30 days. This time limit may be extended by agreement of the parties.

(G) Either an offer of vocational rehabilitation services, or delay or denial notice in accordance with paragraph (2) or (3) of subdivision (a).

(3) Reminder of Potential Eligibility. If the employee has not requested vocational rehabilitation services after notification of medical eligibility, the claims administrator shall remind the employee of his or her right to vocational rehabilitation services. The notice shall be made not earlier than 45 nor later than 70 days after the employee's receipt of the Notice of Potential Eligibility.

(4) Intention to Withhold Maintenance Allowance for Failure to Cooperate. If the employee unreasonably fails to cooperate in the provision of vocational rehabilitation services, the claims administrator shall give the employee written notice of any intention to withhold payment of vocational rehabilitation maintenance allowance, the reasons, and the employee's right to object within 10 days of receiving the notice. The notice shall be made at least 15 days before ending payment of vocational rehabilitation maintenance allowance. The Notice shall include a DWC Form RU 103 "Request for Dispute Resolution".

Note: Authority cited: Sections 59, 133, 138.3, 138.4, 139.5(a)(2), 4636(d), 4637 and 5307.3, Labor Code. Reference: Sections 138.4, 139.5, 4061(a), (b), (d), 4636, 4637, 4641, 4643, 4644, 4650(a)-(d), 4661.5, 4700, 4701, 4702, 4703, 4703.5, 4903(a) and 5402, Labor Code.

HISTORY

1. Repealer filed 7-11-89; operative 10-1-89 (Register 89, No. 28).

2. New section filed 1-7-94; operative 1-7-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 1). For prior history, see Register 89, No. 28.

3. Amendment of subsections (a)(2)-(a)(3)(C), (c)(2), (c)(2)(B)-(E), (d)(2) and (d)(2)(B)-(E) filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No.8).

4. Amendment of subsections (a), (a)(2)-(3), (a)(3)(C), (c)(4)-(d)(1),(d)(2)(A) and (d)(4) filed 12-11-2007; operative 4-9-2008 (Register 2007, No. 50).

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New query

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§9813.1. Notice of Supplemental Job Displacement Benefit, Notice of Offer of Modified or Alternative Work. For Injuries Occurring on or After January 1, 2004.

(a) Notice of Potential Right to Supplemental Job Displacement Benefit (SJDB). Within 10 days of the last payment of temporary disability indemnity, if such notice has not previously been provided, the claims administrator shall advise the employee of his or her potential right to the supplemental job displacement benefit. The claims administrator shall use the mandatory form "Notice of Potential Right to Supplemental Job Displacement Benefit" that is set forth in section 10133.52 of these regulations. The notice shall be sent to the employee by certified mail.

(b) Notice of Offer of Modified or Alternative Work. Within 30 days of the termination of temporary disability indemnity payments, the employer may offer, in the form and manner prescribed by section 10133.53 of these regulations, modified or alternative work accommodating the employee's work restrictions, lasting at least 12 months.
Note: Authority cited: Sections 59, 133, 138.3, 138.4, 4658.5 and 5307.3, Labor Code. Reference: Sections 124, 4658.1, 4658.5 and 4658.6, Labor Code.

HISTORY

1. New section filed 12-11-2007; operative 4-9-2008 (Register 2007, No. 50).

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New query

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§9813.2. Return to Work Notices. For Injuries Occurring on or After January 1, 2005.

Notice of Offer of Regular Work, Notice of Offer of Modified or Alternative Work. Within 60 calendar days from the date that the condition of an injured employee with permanent partial disability becomes permanent and stationary:

(a) If an employer does not serve the employee with a notice of offer of regular work, modified work or alternative work as set forth in section 10002, each payment of permanent partial disability remaining to be paid to the employee from the date of the end of the 60 day period shall be paid in accordance with Labor Code section 4658 (d)(1) and increased by 15 percent.

(b) If an employer serves the employee with a notice of offer of regular work, modified work or alternative work as set forth in section 10002(b)(3) and (4), each payment of permanent partial disability remaining to be paid from the date the offer was served on the employee shall be paid in accordance with Labor Code section 4658 (d)(1) and decreased by 15 percent, regardless of whether the employee accepts or rejects the offer.

(c) The employer shall use Form DWC-AD 10133.53 (Section 10133.53) to offer modified or alternative work, or Form DWC-AD 10003 (Section 10003) to offer regular work. The claims administrator may serve the offer of work on behalf of the employer.

Note: Authority cited: Sections 59, 133, 138.3, 138.4, 4658 and 5307.3, Labor Code. Reference: Sections 124, 4658 and 4658.1, Labor Code.

HISTORY

1. New section filed 12-11-2007; operative 4-9-2008 (Register 2007, No. 50).

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New query

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§9814. Salary Continuation.

In relation to periods of temporary disability, where an employer provides salary or other payments in lieu of or in excess of temporary disability indemnity, the claims administrator or employer shall comply with the notice requirements of this article which apply to temporary disability. In addition, the claims administrator or employer shall include a full explanation of the salary continuation plan with the initial notice.

NOTE: Authority cited: Sections 59, 133, 138.4, 139.5(a)(2), 4637 and 5307.3, Labor Code. Reference: Sections 4650(a), (c), (d), (g), 4800, 4804.1, 4806, 4850-4850.7, Labor Code.

HISTORY

1. Amendment filed 7-11-89; operative 10-1-89 (Register 89, No. 28).

2. Amendment of section and Note filed 1-7-94; operative 1-7-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 1).

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New query

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§9815. Corrected Notice.

If information in any notice, or the action taken as reflected in the notice, was incorrect or incomplete, the claims administrator shall provide the employee with a corrected notice within 14 days of knowledge of the error or omission. The notice shall be identified as a "Corrected Notice" and explain the nature and reason for the correction. Any additional benefits due as a result of the error or omission shall be paid or provided with the notice, if not previously provided.

NOTE: Authority cited: Sections 59, 133, 138.4, 139.5(a)(2), 4637 and 5307.3, Labor Code. Reference: Sections 138.4, 139.5, 4061(a), (b), (d), 4636, 4637, 4641, 4643, 4644, 4650(a) through (d), 4661.5, 4700, 4701, 4702, 4703, 4703.5, 4903(a) and 5402, Labor Code.

HISTORY

1. Amendment of section and Note filed 1-7-94; operative 1-7-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 1).

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New query

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§9816. Enforcement of Reporting Requirements. (Repealed)

NOTE: Authority cited: Sections 138.3 and 138.4, Labor Code. Reference: Sections 138.3, 138.4 and 5453, Labor Code.

HISTORY

1. Repealer filed 1-7-94; operative 1-7-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 1).

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§9817. Destruction of Records. (Repealed)

NOTE: Authority cited: Sections 138.3 and 138.4, Labor Code. Reference: Sections 138.4, 4650, 4651, 4700-4703 and 5402, Labor Code.

HISTORY

1. Repealer filed 1-7-94; operative 1-7-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 1).

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New query

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§9820. Definitions.

As used in this article:

(a) Administrative Director. The Administrative Director of the Division of Workers' Compensation or the Director's duly authorized representative designee, or delegee.

(b) Advertisement. Any form of communication, in writing, photograph or picture, electronic broadcasting or transmission, that solicits any person to:

(1) file a workers' compensation claim, or,

(2) use any workers' compensation services as defined in subsection (k), or,

(3) engage or consult counsel or a medical care provider or clinic to consider a workers' compensation claim.

The form of advertisement may include, but is not limited to, advertising by newspaper, magazine, circular, form letter, publication, billboard, card, label, placard, transit advertisement, business card, envelope, book, list, directory, radio, motion picture, video, television, or electronic mail.

(c) Advertiser. Any person who sends, publishes, broadcasts, transmits or communicates an advertisement as defined in subsection (b); or who causes or pays in whole or in part for the sending, publishing, broadcasting, transmission or communication of such an advertisement either for himself or on behalf of another person. However, advertiser does not include the following persons if the person's principal business is other than providing workers' compensation services:

(1) a publisher, printer, distributor or circulator of a newspaper, magazine, book, or other writing;

(2) an operator of a broadcasting station, movie or video production company;

(3) an operator of premises where advertisements are displayed;

(4) a person while working as an employee of any persons exempted in paragraphs 1 through 3 of this subsection.

(d) Attorney. A person who holds a valid, active license to practice law in California at the time the advertisement governed by these regulations is published.

(e) False or misleading advertisement. An advertisement that:

(1) Is false or misleading pursuant to Labor Code Section 139.43(a) or 139.45(b).

(2) Violates any provision of Labor Code Section 5433.

(3) Offers or implies that the advertiser can or will dissuade, delay or impede a claimant from pursuing a legitimate work injury claim; or can or will provide false or inaccurate evidence or opinion in support of or in opposition to a work injury claim.

(4) Fails to include the notice as specified in Labor Code Section 5432 or Title 8 CCR Section 9823(b).

(5) Fails to comply with any requirement of this article.

(6) Is placed in furtherance of business operations conducted in violation of law, or when the advertiser has not complied with any requirement of this article.

(f) Him, Himself or His. These terms include "her", "herself" or "hers" when the person is female, and "it", "itself" or "its" when referring to an artificial person.

(g) Owner. A person who has a direct or indirect ownership interest in a business which provides workers' compensation services, or a person who has a direct or indirect claim to all or a portion of the income of a business which provides workers' compensation services.

(h) Person. Any natural or artificial person or combination of persons, including without limitation a corporation, partnership, trust, or unincorporated association.

(i) Physician. A person who holds a valid, active license to practice in California at the time the advertisement governed by these regulations is published, as any of the following medical practitioners: a medical or osteopathic physician and surgeon; a psychologist; a chiropractor; a podiatrist; a dentist; or an optometrist.

(j) Referral panelist. A person who will receive or has agreed to receive referrals of clients from a workers' compensation referral service.

(k) Workers' compensation services means services provided by any of the following:

(1) A workers' compensation medical or medical-legal provider, which means any person who provides medical treatment or evaluation of injuries or alleged injuries, including work injuries.

(2) A workers' compensation non-attorney advisor or representative, which means any person who is not an attorney who advises or represents persons in connection with injuries or alleged injuries, including work injuries.

(3) A workers' compensation referral service, which means any person who refers persons to medical or medical-legal providers, non-attorney advisors or representatives, or attorneys who advise or represent persons in connection with injuries or alleged injuries, including work injuries.

(4) A workers' compensation advertiser, which means any person who advertises or solicits for any or all of the preceding three categories of persons.

This definition includes persons who provide services for several types of injuries, as long as work injuries are included.

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New Article 8.1 and section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

2. Amendment of article 8.1 heading filed 8-7-95; operative 8-7-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 32).

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New query

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§9821. Coverage and Exclusions.

(a) This article does not apply to attorneys, as defined in Section 9820(d), or physicians, as defined in Section 9820(i). Nothing in this article shall be construed to obviate or lessen the obligations of attorneys or physicians under Labor Code Sections 5430 through 5434, or under other provisions of law. A person who was not licensed to practice in California at the time of the act or omission is not considered an attorney or physician under this article, and these regulations apply to such a person.

(b) This article does not apply to government agencies, labor organizations as defined in Labor Code Section 1117, charitable organizations, or non-profit tax-exempt bar associations whose primary business or purpose is other than providing workers' compensation services as defined in Section 9820(k), or to agents or employees of any of these exempt entities while acting for them.

(c) This article does apply to all other advertisers, as defined in Section 9820(c), even though an advertiser who is subject to this article may also be subject to attorney or physician workers' compensation advertising laws because the person advertises with or for an attorney or physician.

(d) The provisions of this article are not exclusive. The Administrative Director may use the remedies in this article and any other remedies provided by law.

(e) Any waiver of this article is void as against public policy.

(f) This article shall not be construed to authorize the unlawful practice of law or medicine by any person.

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

2. Amendment of subsection (a) filed 8-7-95; operative 8-7-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 32).

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§9822. Severability.

If any portion of this article, or the application of any part of it to any person or circumstance, is held to be invalid, the rest of the article and its application to any other person or circumstance remain valid.

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9823. General Workers' Compensation Advertising Rules.

All advertisements shall comply with the following rules:

(a) No advertisement shall be false or misleading.

(b) All advertisements shall include the written or spoken fraud notices, in the manner set forth in Labor Code Section 5432(a), (b).

(c) If an advertisement includes a testimonial, it must not overstate or distort the facts or results of the person's case, and must qualify the testimonial by stating immediately before or after it: (1) that each person's case is different and that the reader's or viewer's results will not necessarily be the same as the example; (2) in the case of a spoken or pictorial testimonial when the speaker is not relating his or her own experience, that the reader, model or performer is an actor and not the actual person involved in the case. The advertisement must give the qualifying information in a similar manner and with similar emphasis as the testimonial.

(d) The advertiser must identify himself either by his true legal name or by a fictitious business name that was duly filed under Division 7, Part 3, Chapter 5 of the Business & Professions Code before using the fictitious name in an advertisement, and which fictitious name filing had not expired at the time of the advertisement. However, no such advertised name shall violate subsection (e). Notwithstanding the general provisions of the fictitious business name law, an advertiser must file its fictitious business statement before using it in an advertisement.

(e) An advertisement for a person who is not a physician (as defined in Section 9820(i)) may not use the terms "medical", "physician", or "doctor"; nor a term describing a specific area of medical practice such as "surgeon", "osteopath", "psychologist", "chiropractor", "podiatrist", "dentist", "optometrist", etc.; nor their linguistic variants; nor any similar designation implying that the person is a physician; in the advertiser's name or to describe the advertiser's services. In addition, an advertisement for a person who is not licensed as a physician in the specific area of medical practice named in the advertisement may not include a term describing a specific area of medical practice. However, an advertisement for a medical referral service may use the terms as provided in Section 9828(a).

(f) An advertisement for a person who is not an attorney (as defined in Section 9820(d)) may not use the terms "legal", "attorney", "law firm", "law office", "law center", "counselor at law", "specialist in workers' compensation law"; nor their linguistic variants; nor any similar designation implying that the person is an attorney; in the advertiser's name nor to describe the advertiser's services. However, an advertisement for a legal referral service may use the terms as provided in Section 9828(b).

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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New query

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§9824. Identification as Representative.

An advertisement for a workers' compensation non-attorney advisor or representative shall identify the advertiser as a non-attorney as follows: "The advertiser is a representative [or an advisor] who is not an attorney." This notice shall be advertised in the same manner (size, typeface, display, etc.) required for the notice specified in Section 9823(b).

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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New query

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§9825. Representative's WCAB Qualification.

No person shall advertise as or on behalf of a non-attorney advisor or representative whose right to practice before the Workers' Compensation Appeals Board is suspended or revoked when the advertisement is published.

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9826. Advertisement by Unlicensed Attorney.

No person shall advertise as or on behalf of a non-attorney advisor or representative whose California license to practice law is suspended or revoked when the advertisement is published, without stating in the advertisement: "The advertiser is a representative [or an advisor] whose license to practice law has been suspended [or revoked]." This notice shall be advertised in the same manner (size, typeface, display, etc.) required for the notice specified in Section 9823(b). This section does not permit advertising by a person whose right to practice before the WCAB, as well as his license to practice law, is suspended or revoked.

NOTE: Authority cited: Sections 59, 13, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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New query

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§9827. Advertisement by Unlicensed Medical Provider.

No person shall advertise medical goods or services whose provision requires a license, by or on behalf of a person who does not hold a valid, active license to provide the goods or services when the advertisement is published.

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9828. Use of Terms "Medical", "Legal", or Comparable Terms.

An advertisement for workers' compensation referral services shall not use any of the following terms or their linguistic variants, nor any similar designation, in its name or to describe its services: (1) "medical", "physician", or "doctor"; (2) a term describing a specific area of medical practice such as "surgeon", "osteopath", "psychologist", "chiropractor", "podiatrist", "dentist", "surgeon", "optometrist", or the like; (3) "legal", "attorney", "law firm", "law office", "law center", "counselor at law", "specialist in workers' compensation law", except:

(a) An advertisement for a medical referral service may use the terms "medical referral" or "physician referral" if the service refers persons who respond to the advertisement only to physicians (as defined in Subsection 9820(i)). It may also use the term "medical referral" if it refers for goods or services by medical providers outside the fields of practice listed in subsection 9820(i), only to persons licensed to provide those other goods or services. It may use the term "referral" preceded by the name of a specific type of physician, such as "chiropractic referral", "podiatric referral", etc., if it restricts its referrals to physicians of the type named.

(b) An advertisement for a legal referral service may use the terms "legal referral" or "attorney referral" if the service refers persons who respond to the advertisement only to attorneys (as defined in Subsection 9820(d)).

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9829. Information Required from Referral Panelists.

Each advertiser of workers' compensation referral services shall require each medical, legal or non-attorney advisor or representative who will receive referrals from the referral service to supply the following information in writing, before receiving any referrals:

(a) In the case of all referral panelists, the information required by Section 9831.

(b) In the case of all referral panelists, an agreement that the panelist will inform the referral service in writing of any change in the information supplied, within 10 days of the change.

(c) In the case of an attorney, physician or other medical care referral panelist, the date the panelist was licensed to practice in California (if a license is required for that field of practice); that the license is then active and in good standing; and the panelist's specialty area of practice, if any, including the name of any specialty board or certification and date of that certification which the panelist holds.

(d) In the case of a non-attorney advisor or representative, a statement that the panelist is then entitled to appear before the Workers' Compensation Appeals Board.

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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New query

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§9830. Information Supplied to Referral Panelists.

Each advertiser of workers' compensation referral services shall give each referral panelist a copy of each advertisement it will use to refer clients to the panelist, on or before the date the advertisement is published. The advertiser shall notify the panelist in writing, with the copy of the advertisement, that the panelist may object to the advertiser's using that advertisement to attract or refer clients to the panelist. If a panelist notifies the service that (s)he objects to the advertisement, the service shall not refer any clients who respond to that advertisement to a panelist who objected to it.

The advertiser shall maintain written records of each objection to an advertisement, containing a copy of the advertisement, the identity of the panelist who objected to it, and the date of the objection. During the period any objection is in force to an advertisement then being published, the advertiser shall ask each respondent to identify the advertisement to which the person is responding, and shall not refer the respondent to any panelist who objected to that advertisement.

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9831. Registration Statement.

Every advertiser shall prepare, retain, and make available to the administrative director upon request a written registration statement. The information in the statement shall be verified by a declaration under penalty of perjury signed by the advertiser (if an individual), or by each owner of the advertiser (if a business entity). Whenever a material change occurs in the information in the statement, the advertiser shall within 10 days of the change revise the statement.

The statement shall contain the following information:

(a) The full legal name of the advertiser, and any other name(s) under which the person will advertise or do business.

(b) The advertiser's business form and place of organization; if the advertiser is a corporation, a copy of its articles of incorporation and bylaws and any amendments to them; if the advertiser is a partnership, a copy of the partnership agreement and any amendments to it; if the advertiser is an unincorporated organization a copy of its written organizational documents and any amendments to them; if the advertiser has filed or uses a fictitious business name, a copy of each fictitious business name statement showing the place(s) of filing.

(c) The complete street address or addresses of all locations at which the advertiser does or proposes to do business, and a designation of one such location in California as its principal place of business in the state.

(d) A listing of all telephone numbers to be used by the advertiser and the address where each telephone using each of these telephone numbers is located.

(e) The name of, and the office held by, the advertiser's officers, directors, trustees, general and limited partners, sole proprietor, and owners, as the case may be, and the names of those persons who have management responsibilities in connection with the advertiser's business activities.

(f) For each person whose name is disclosed under subdivision (e): the complete address of his principal residence; his driver's license number and state of issuance; and the number, licensing agency, and status of each professional license (s)he holds.

(g) A statement identifying any person disclosed under subdivision (e) who:

(1) has been convicted of or has pleaded guilty or no contest to a felony or misdemeanor violation of any offense related to workers' compensation, or of fraud, theft, embezzlement, fraudulent conversion, or misappropriation of property; or

(2) is or has been the subject of any civil or administrative action alleging acts in violation of any workers' compensation law, or of fraud, theft, embezzlement, fraudulent conversion, or misappropriation of property, or of the use of unfair, unlawful, or deceptive business practices.

The statement shall identify the person, court or administrative agency in which the case was filed, the case number, title of the case, and the result of the case.

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9832. Maintenance of and Access to Records.

Every advertiser shall maintain the following records, at its principal place of business in California, of its business of providing workers' compensation services:

(a) Complete financial records using generally accepted accounting principles, as defined by the American Institute of Certified Public Accountants and the Financial Standards Board.

(b) A copy of all of its workers' compensation advertisements (whether in print, video or audio media) published within the preceding two years. The records shall include a copy of the advertisement and the dates and places of each publication, including as applicable the name and city of publication of a periodical, or the station call letters and city location of any radio or television station.

(c) Its registration statement required by Section 9831.

(d) For workers' compensation referral services, a record of all objections to advertisements as required by Section 9830.

(e) For workers' compensation referral services, a single record listing all referral panelists, including each panelist's: (1) name; (2) address(es) at which (s)he will consult with clients; (3) profession, professional license number and state of issuance; (4) if the panelist works for a business, the name of the business and his status with it (owner, employee or independent contractor); (5) date (s)he became a panelist; and (6) the date (s)he ended the status as a panelist if applicable.

The service shall update the record to show any change in a panelist's status within 10 days of knowledge of the change. The record shall continue to list each panelist who ends his status as such, for two years after the person's status as a panelist ended.

(f) The advertiser shall maintain all records required by this section for at least two years after: (1) for advertisements, the date of its last publication; (2) for financial records, the end of the calendar year to which the records refer in whole or in part; (3) for registration statements or statement changes, the end of the calendar year to which the statement or change relates; (4) for objections to advertisements, the later of the date of the objection or the date the advertisement was last published; (5) for the combined listing of referral panelists required by Subsection (e) (in its current updated form), the date the service publishes its last advertisement.

(g) The advertiser shall make all records required by this section available for inspection and copying by any

representative of the Department of Industrial Relations, the Department of Justice, or district or city attorney, during the advertiser's normal business hours but at least between 9:00 a.m. and 5:00 p.m. Monday through Friday (excepting holidays). In addition, if necessary in the judgment of the inspector to protect the integrity of an investigation, the advertiser shall allow, and an inspector may conduct or continue inspection and copying during other hours or days.

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code; Sections 11180-11191, Government Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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New query

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§9833. Right to Conduct Investigation.

The Administrative Director may investigate any violation of this article, of the Workers' Compensation Truth in Advertising Act of 1992 (Labor Code §§5430 et seq.), of Section 139.43 of the Labor Code, or of any other provision of law now or hereafter enacted concerning workers' compensation advertising by persons other than attorneys or physicians. For this purpose (s)he may employ all rights and remedies possessed or delegated under Government Code §§11180 et seq.

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code; Sections 11180-11191, Government Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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New query

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§9834. Order to Produce Documents or Provide Information.

The Administrative Director may issue and serve on any advertiser, or the advertiser's employees or agents, an order requiring the advertiser, employee or agent to provide information, copies and access to any information related to workers' compensation advertising subject to regulation under this article. The advertiser, employee or agent shall comply with the order within the time specified in it. The Administrative Director may serve the order by any method reasonably calculated to give notice to the person served.

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 133.49(a), (b), (d), 139.45 and 5430-5434, Labor Code; Sections 11180-11191, Government Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

2. Editorial correction of Note (Register 98, No. 46).

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§9835. Compliance Orders.

(a) The Administrative Director may issue and serve on any advertiser, or the advertiser's employees or agents, a compliance order requiring the advertiser, employee or agent to cease and desist from committing any violation, or to comply with any requirement, of this article. The Administrative Director may serve the order by any method reasonably calculated to give notice to the person served.

(b) The Administrative Director's order may include, but is not limited to, the following provisions: (1) an order to stop using an advertisement or to use it only with specified modifications; (2) an order to advertise or otherwise disseminate corrective information, either by the advertiser at its expense, or by the Administrative Director at the advertiser's expense; (3) an order to pay the Administrative Director's investigation and enforcement costs.

(c) The advertiser, employee or agent shall comply with the order within the time specified in it.

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9836. Other Remedies; Cumulative Remedies.

The Administrative Director may institute civil proceedings against any person for violation of this article or of the statutes which may be investigated under this article, or may refer any violation for civil, criminal or professional disciplinary proceedings to the Attorney General, a district or city attorney, or other authorities having jurisdiction of the matter.

The Administrative Director's remedies in this article are cumulative and not exclusive, and the exercise of any or all of them is discretionary.

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9837. Hearing.

(a) Any person aggrieved by an order issued under Sections 9834 or 9835 may request a hearing before the administrative director or an administrative law judge which shall be shall be held in accordance with the Administrative Procedure Act {Chapter 5, (commencing with Section 11500), of Part 1 of Division 3 of Title 2 of the Government Code}, and the administrative director shall have all of the powers granted under that act.

NOTE: Authority cited: Sections 59, 133, 139.43(b) and 5307.3, Labor Code. Reference: Sections 7, 139.43(a), (b), (d), 139.45 and 5430-5434, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

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§9880. Written Notice to New Employees.

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a) Every employer shall provide to every new employee, either at the time of hire or by the end of the first pay period, the Written Notice to New Employees concerning the rights, benefits and obligations under worker's compensation law. The content of the notice must be approved by the Administrative Director.

(b) The notice shall be easily understandable. It shall be available in both English and Spanish where there are Spanish-speaking employees.

(c) The notice provided shall be in writing, in non-technical terms and shall include the following information:

(1) The name of the current compensation insurance carrier of the employer at the time of distribution, or when such is the fact, that the employer is self-insured, and who is responsible for claims adjustment;

(2) How to get emergency medical treatment, if needed;

(3) The kind of events, injuries and illnesses covered by workers' compensation;

(4) The injured employee's right to receive medical care;

(5) How to obtain appropriate medical care for a job injury;

(6) The role and function of the primary treating physician;

(7) The rights of the employee to select and change the treating physician pursuant to the provisions of Labor Code Sections 4600 to 4601, including the right to predesignate a personal physician or medical group;

(8) A form that the employee may use as an optional method for notifying the employer of the name of the employee's “personal physician,” as defined by Labor Code Section 4600, or “personal chiropractor,” as defined by Labor Code Section 4601;

(9) The rights of the employee to receive temporary disability indemnity, permanent disability indemnity, supplemental job displacement benefits, and death benefits, as appropriate;

(10) To whom the injuries should be reported;

(11) The existence of time limits for the employer to be notified of an occupational injury;

(12) The protections against discrimination provided pursuant to Section 132a;

(13) The location and telephone number of the nearest information and assistance officer, including an explanation of services available; and

(14) A description about Medical Provider Networks (“MPN”) which includes that the employer may be using a MPN, what a MPN is, the predesignation exemption from the MPN, when an employee must begin to use a physician from the MPN, and how to request information about using a MPN.

Note: Authority cited: Sections 133, 138.3, 138.4, 3550, 3551, 4603.5 and 5307.3, Labor Code. Reference: Sections 132(a), 139.6, 3550, 3551, 3600, 4600, 4601, 4603, 4650, 4651, 4656, 4658.5, 4658.6, 4700, 4702, 4703, 5400 and 5401, Labor Code.

HISTORY

1. New Article 8.5 (Sections 9880-9882) filed 1-28-76 as an emergency; effective upon filing (Register 76, No. 5).

2. Certificate of Compliance filed 1-29-76 (Register 76, No. 5).

3. Repealer and new section filed 11-9-77; effective thirtieth day thereafter (Register 77, No. 46).

4. Amendment filed 10-16-81; effective thirtieth day thereafter (Register 81, No. 42).

5. Editorial correction restoring Article 8.5 (Sections 9880-9883), which was inadvertently repealed by a 7-15-83 order (Register 83, No. 33).

6. Repealer and new section filed 7-11-89; operative 10-1-89 (Register 89, No. 28).

7. Amendment of section and Note filed 7-7-2004; operative 8-1-2004 pursuant to Government Code section 11343.4 (Register 2004, No. 28).

8. Amendment of subsections (c)(7), (c)(9) and (c)(12)-(13), new subsection (c)(14) and amendment of Note filed 8-9-2010; operative 10-8-2010 (Register 2010, No. 33).

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§9881. Posting of Notice to Employees.

(a) Every employer shall post and keep posted in a conspicuous location frequented by employees during the hours of the workday a Notice to Employees.

(b) The Notice to Employees poster shall be easily understandable. It shall be posted in both English and Spanish where there are Spanish-speaking employees.

(c) The Notice to Employees poster shall include the following information:

(1) The name of the current compensation insurance carrier of the employer, or when such is the fact, that the employer is self-insured, and who is responsible for claims adjustment.

(2) How to get emergency medical treatment, if needed.

(3) Emergency telephone number(s), for hospital, ambulance, police and firefighting services.

(4) The kinds of events, injuries and illnesses covered by workers' compensation.

(5) Advice that the employer may not be responsible for compensation because of an injury due to the employee's voluntary participation in any off-duty recreational, social, or athletic activity that is not a part of the employee's work-related duties.

(6) The injured employee's right to receive medical care.

(7) The rights of the employee to select and change the treating physician pursuant to the provisions of Labor Code Section 4600, including the right to predesignate a personal physician or medical group.

(8) The rights of the employee to receive temporary disability indemnity, permanent disability indemnity, supplemental job displacement benefits, and death benefits, as appropriate.

(9) To whom the injuries should be reported.

(10) The existence of time limits for the employer to be notified of an occupational injury.

(11) The protections against discrimination provided pursuant to Labor Code Section 132a.

(12) The location and telephone number of the nearest information and assistance officer.

(13) A description about Medical Provider Networks (“MPN”) which includes what a MPN is, the predesignation exemption from the MPN, when an employee must begin to use a physician from the MPN, and how to request information about using a MPN. The MPN Contact telephone number, address and, if available, the MPN website address/URL shall be included. The effective date of MPN coverage for the MPN being used by the employer to cover current injuries shall also be stated if the employer is using an MPN.

(d) The employer may post the Administrative Director's approved Notice to Employee Poster provided in Section 9881.1. If the employer chooses not to use the Notice to Employee Poster provided in Section 9881.1, the employer may use a poster which meets the posting requirements of Labor Code Section 3550, includes the information required by this regulation, and has been approved by the Administrative Director.

Note: Authority cited: Sections 133, 138.3, 139.6, 3550, 4603.5 and 5307.3, Labor Code. Reference: Sections 132(a), 139.6, 3550, 3600, 4600, 4601, 4603, 4616, 4656, 4658.5, 4658.6, 5400 and 5401, Labor Code.

HISTORY

1. Repealer and new section filed 7-11-89; operative 10-1-89 (Register 89, No. 28).

2. Amendment of section heading, section and Note filed 7-7-2004; operative 8-1-2004 pursuant to Government Code section 11343.4 (Register 2004, No. 28).

3. Amendment of subsections (c)(3) and (c)(7)-(8), new subsection (c)(13), redesignation of second subsection (c) as new subsection (d) and amendment of Note filed 8-9-2010; operative 10-8-2010 (Register 2010, No. 33).

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§9882. Written Notice to Injured Employees; Pamphlet Contents.

NOTE

Authority cited: Sections 133, 138.3, 138.4, 139.6, and 5402, Labor Code. Reference: Sections 132(a), 139.5, 3600, 4600, 4601, 4650, 4658, 4700, 4701, 4702, 4703, 4401-4411 and 5400-5412, Labor Code.

HISTORY

1. Repealer and new section filed 7-11-89; operative 10-1-89 (Register 89, No. 28).

2. Repealer filed 7-7-2004; operative 8-1-2004 pursuant to Government Code section 11343.4 (Register 2004, No. 28).

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§9883. Publication of Information, Approval, Spanish Translation.

(a) Insurers, employers or private enterprises may prepare and publish for their use or sale the Notice to Employees poster and/or the Written Notice to New Employees required by this Article upon prior approval of the form and content by the Administrative Director. The Notice to Employees poster and/or Written Notice to New Employees may include a logotype. The addition only of a logotype to a previously approved Notice to Employees poster or Written Notice to New Employees does not require additional approval.

(1) Any published Written Notice to New Employees shall be available in English and Spanish and shall include the information specified in Section 9880.

(2) Any published Notice to Employees poster shall be available in English and Spanish, where there are Spanish-speaking employees, and shall include the information specified in Section 9881.

(b) All matter published subsequent to the effective date of this regulation shall indicate that the written informational material has been approved by the Administrative Director.

(c) Publications other than those of the Administrative Director or the Workers' Compensation Appeals Board may reflect the employer, private publisher or insurance carrier identifier or logotype.

NOTE

Authority cited: Sections 133, 139.6, 3550, 3551 and 5307, Labor Code. Reference: Sections 139.6, 3550 and 3551, Labor Code.

HISTORY

1. New section filed 7-27-79; effective thirtieth day thereafter (Register 79, No. 30).

2. Change without regulatory effect of NOTE filed 7-11-86; effective upon filing (Register 86, No. 28).

3. Repealer and new section filed 7-11-89; operative 10-1-89 (Register 89, No. 28).

4. Amendment of section and Note filed 7-7-2004; operative 8-1-2004 pursuant to Government Code section 11343.4 (Register 2004, No. 28).

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§9884. Exceptions.

The requirements of this article shall not apply to injuries where the employee files an application for adjudication of claim with the appeals board.

NOTE: Authority cited: Sections 138.4, Labor Code. Reference: Section 5402, Labor Code.

HISTORY

1. New section filed 7-11-89; operative 10-1-89 (Register 89, No. 28).

2. Editorial correction to History 1 (Register 96, No. 52).

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Article 9. Computation of Life Pensions, Tables For

New query

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§9885. U.S. Life Tables. (Repealed)

NOTE: Authority cited: Sections 127, 133, 138.2, 138.3, 139.5, 139.6, 4603.2, 4603.5, 5307.1, 5307.3, 5450-5455, Labor Code.

HISTORY

1. New section filed 11-9-70; designated effective 1-1-71 (Register 70, No. 46).

2. Amendment filed 11-9-77; effective thirtieth day thereafter (Register 77, No. 46).

3. Amendment filed 8-29-84; effective thirtieth day thereafter (Register 84, No. 35).

4. Repealer of article 9 (section 9885) and section filed 1-17-2001; operative 1-17-2001 pursuant to Government Code section 11343.4(c) (Register 2001, No. 3).

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New query

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§9900. Employer.

(a) Each employer shall notify the Administrative Director of the death of every employee, regardless of the cause of death, except where the employer has actual knowledge or notice that the deceased employee left a surviving minor child.

(b) Notification shall be made on the Division of Industrial Accidents Form 510, "Notice of Employee Death" (See Section 9910).

(c) The Notice of Employee Death shall be filed within 60 days of the employer's notice or knowledge of the employee death.

(d) The employer may forward the "Notice of Employee Death" to his workmen's compensation insurer for subsequent submission to the Administrative Director.

NOTE: Authority cited: Sections 133, 138.2, 138.3, 139.5, 139.6, 4603.2, 4603.5, 5307.1, 5307.3, 5450-5455, Labor Code.

HISTORY

1. Amendment of subsection (a) filed 11-9-77; effective thirtieth day thereafter (Register 77, No. 46). For prior history, see Register 73, No. 28.

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§9905. Notice.

If the Notice required in Section 9900 is incomplete or otherwise deficient, the Administrative Director may require a further explanation or additional information from the employer, or his insurance carrier.

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New query

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§9910. DIA Form 510: Notice of Employee Death.

DIA Form 510, Notice of Employee Death. (.pdf format, 4K)

HISTORY

1. Amendment filed 7-11-73 as an emergency; effective upon filing. Certificate of Compliance included (Register 73, No. 28).

2. Amendment filed 11-9-77; effective thirtieth day thereafter (Register 77, No. 46).

3. Repealer and new section filed 8-29-84; effective thirtieth day thereafter (Register 84, No. 35).

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§9914. Reproduction of Form 510, Notice of Employee Death.

(a) Employers and insurers may reproduce DIA Form 510, in which the heading may be rearranged to permit printing of:

(1) The insurance carrier's or employer's name, address and telephone number.

(2) Instructions for forwarding the form and number of copies required.

(b) The spacing, arrangement, sequence or language shall not otherwise be altered.

HISTORY

1. Amendment filed 7-11-73 as an emergency; effective upon filing. Certificate of Compliance included (Register 73, No. 28).

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§9918. Service on Administrative Director.

The Notice of Employee Death, DIA Form 510, shall be mailed to the Administrative Director, Division of Industrial Accidents, P. O. Box 42400, San Francisco, California 94142.

This P. O. Box is to be used only for the notices required in Section 9900 and not for any other functions of the Administrative Director or Division of Industrial Accidents.

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§9920. Authority. (Repealed)

NOTE: Authority cited: Sections 127, 133, 138.2, 138.3, 139.5, 139.6, 4603.2, 4603.5, 5307.1, 5307.3, 5451-5454, Labor Code.

HISTORY

1. New Article 10.5 (Sections 9920-9929) filed 11-9-77; effective thirtieth day thereafter (Register 77, No. 46).

2. Repealer filed 10-16-81; effective thirtieth day thereafter (Register 81, No. 42).

3. Amendment of Article 10.5 heading filed 2-16-95; operative 2-16-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 7).

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§9921. Operative Date.

The provisions of this Article are effective immediately upon adoption.

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New query

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§9922. Purpose.

This Article is being adopted to implement Section 139.6 and Article 2.5 of Part 4 of Division 4 of the Labor Code by providing that the State, through the Division of Workers' Compensation, establish an affirmative impartial service to employees, employers, claims administrators, labor unions, medical providers, and all others subject to or interested in the workers' compensation laws of the State of California. This service shall be provided so that all such parties are informed of the provisions of the workers' compensation laws, that benefits due are paid promptly, that disputes and misunderstandings are resolved informally insofar as possible, and that premature and unnecessary litigation be minimized.

NOTE: Authority cited: Sections 133, 139.6, 5307.3 and 5450, Labor Code. Reference: Sections 5450-5455, Labor Code.

HISTORY

1. Amendment filed 2-16-95; operative 2-16-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 7).

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§9923. Designation.

(a) Pursuant to Labor Code Section 139.6, the Administrative Director shall appoint a person or persons thoroughly familiar with the Workers' Compensation Program in California to be responsible for informing the general public, labor unions, employees, employers, claims administrators, medical providers and all other interested parties of the rights, benefits and obligations of the workers' compensation law, including the creation and existence of the Information and Assistance Program.

(b) In each district office of the Division of Workers' Compensation (Workers' Compensation Appeals Board) and at the Division headquarters the Administrative Director shall appoint an Information and Assistance Officer, and such Deputy Information and Assistance Officers as the work of the district office and headquarters may require. The Administrative Director shall provide office facilities and clerical support appropriate to the functions of such Information and Assistance Officer.

NOTE: Authority cited: Sections 133, 139.6, 5307.3 and 5450, Labor Code. Reference: Sections 5450-5455, Labor Code.

HISTORY

1. Amendment filed 2-16-95; operative 2-16-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 7).

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§9924. Scope of Duties.

Each Information and Assistance Officer shall be responsible for the performance of the following duties:

(a) Provide continuing information concerning the rights, benefits and obligations under the workers' compensation laws of the State of California to employees, employers, medical providers, claims administrators and other interested parties.

(b) Assist in the prompt resolution of misunderstandings, disputes, and controversies arising out of claims for compensation, without formal proceedings, to the end that full and timely compensation benefits are furnished.

(c) Distribute such information pamphlets in English, Spanish and other languages as needed that have been prepared and approved by the Administrative Director to all inquiring employees and to such other parties that may request copies of the same.

(d) Establish and maintain liaison with the persons located in the geographic area served by the district office, with other affected State agencies, with organizations representing employees, employers, claims administrators and the medical community.

(e) Discharge such other duties consistent with the purposes of this Article as from time to time may be delegated by the Administrative Director.

NOTE: Authority cited: Sections 133, 139.6, 5307.3 and 5451, Labor Code. Reference: Sections 5450-5455, Labor Code.

HISTORY

1. Amendment of subsections (a), (c) and (d) filed 2-16-95; operative 2-16-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 7).

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§9925. Use of Other Division Facilities.

In undertaking his or her duties, the Information and Assistance Officer may use the services of the Industrial Medical Council, the Disability Evaluation Unit, the Rehabilitation Unit, the Audit Unit and any other unit or units of the Division of Workers' Compensation available to aid in the resolution of disputes.

Copies of medical reports, permanent disability rating evaluations, earnings data and other pertinent information obtained by the Information and Assistance Officer shall be furnished to all parties involved in a dispute.

NOTE: Authority cited: Sections 133, 136.6, 5307.3 and 5451, Labor Code. Reference: Sections 5450-5455, Labor Code.

HISTORY

1. Amendment filed 2-16-95; operative 2-16-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 7).

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§9926. Referrals to a Qualified Medical Evaluator.

Upon the submission of a matter to an Information and Assistance Officer, the Officer, with the agreement of a party to pay the cost and with the consent of an unrepresented employee, may request that the Administrative Director direct the injured employee to be examined by a Qualified Medical Evaluator selected by the Medical Director, within the scope of the qualified medical evaluator's professional training, for the purpose of addressing any pertinent clinical question other than those issues specified in Labor Code Section 4061.

NOTE: Authority cited: Sections 133, 139.6, 5307.3, 5451 and 5703.5(b), Labor Code. Reference: Sections 5450-5455, Labor Code.

HISTORY

1. Amendment of section heading and section filed 2-16-95; operative 2-16-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 7).

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§9927. Jurisdiction.

(a) Any party to a claim may consult with an Information and Assistance Officer at any time to seek advice and assistance in the resolution of any misunderstanding, dispute, or controversy. The request for assistance need not be in writing, or be in any particular form, but it shall apprise the Information and Assistance Officer of the nature of the dispute and any other pertinent information to facilitate an appropriate inquiry by the Information and Assistance Officer. The Information and Assistance Officer shall communicate with the parties and provide information and assistance in resolving disputes.

(b) If an Application for Adjudication of Claim has been filed with the Workers' Compensation Appeals Board, any party may consult with an Information and Assistance Officer to seek assistance in resolving controverted issues or misunderstandings at any time prior to the filing of a Declaration of Readiness to Proceed. If the employee is not represented or by consent of the parties, the Information and Assistance Officer may continue to provide assistance after a filing of a Declaration of Readiness to Proceed.

(c) The Information and Assistance Officer shall provide assistance to asbestos workers in obtaining benefits from the Asbestos Workers' Account and/or the responsible employer pursuant to Section 4410 of the Labor Code.

(d) When the injured worker is not represented by an attorney or other representative, and either a Compromise and Release agreement or Stipulations with Request for Award, other than those presented at or subsequent to a regularly scheduled hearing, has been filed with the Workers' Compensation Appeals Board, the information and assistance officer shall: review the documents; contact the parties when indicated; coordinate with other units within the Division of Workers' Compensation; seek to determine that the employee is aware of the significance of the agreement; and make recommendations to the parties and the workers` compensation judge. The Manager of the Information and Assistance Unit shall notify the Presiding Workers' Compensation Judge when this service cannot be provided timely.

NOTE: Authority cited: Sections 133, 139.6, 5307.3 and 5451, Labor Code. Reference: Sections 5450-5455, Labor Code.

HISTORY

1. Amendment filed 10-16-81; effective thirtieth day thereafter (Register 81, No. 42).

2. Amendment filed 7-15-83; effective thirtieth day thereafter (Register 83, No. 30).

3. Editorial correction of 7-15-83 order redesignating effective date to 8-1-83 pursuant to Government Code Section 11346.2(d) filed 7-19-83 (Register 83, No. 30).

4. Repealer of subsection (d), subsection relettering and amendment of newly designated subsection (d) filed 2-16-95; operative 2-16-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 7).

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§9928. Procedures for Mediation and Recommendations.

(a) The Information and Assistance Officer is not bound by technical or formal rules of procedure but may make inquiries into any matter referred to him or her in a manner best suited to protect the rights of all parties and to achieve substantial justice.

(b) When there is a dispute regarding the provision of workers' compensation benefits, the employee, claims administrator or any party may request the Information and Assistance Officer to mediate the dispute. The Information and Assistance Officer will attempt to resolve the dispute by mediation, which may include a conference. The officer shall make appropriate inquiries to determine the contentions of the parties, identify the matters which may prevent amicable resolution, and afford all parties an opportunity to present their positions.

(c) In the event a dispute is not resolved through mediation, the Information and Assistance Officer shall issue a recommendation as soon as possible.

(d) In order to toll the statutes of limitations pursuant to Section 5454 of the Labor Code, the Information and Assistance Officer must notify in writing all parties to any misunderstanding, dispute or controversy of the fact that said Information and Assistance Officer has taken under consideration the misunderstanding, dispute or controversy submitted to him or her for a recommendation.

(e) Upon issuing a recommendation, the Officer shall advise the parties of his or her recommendation in a written communication which describes in non-technical terms the nature of the differences, the proposed resolution and the rationale used in arriving at that resolution. The communication shall also advise the parties that the tolling of any applicable statute of limitations will cease 60 days after the issuance of the recommendation, and shall further advise the parties of their right to obtain a decision from the appeals board if the recommendation is not accepted by the parties. In the event a party does not accept the recommendation of the Information and Assistance Officer, the party must notify all other parties in writing within 30 days of receipt of the recommendation. Where the Information and Assistance Officer feels that further mediation may resolve the dispute, he or she will notify the parties of the availability of the Information and Assistance Officer to provide such further mediation.

NOTE: Authority cited: Sections 133, 139.6, 5307.3, 5451 and 5453, Labor Code. Reference: Sections 5450-5455, Labor Code.

HISTORY

1. Amendment of section heading and subsections (b), (c) and (e) filed 2-16-95; operative 2-16-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 7).

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§9928.1. Procedures for Asbestos Workers.

When consulted by an asbestos worker or his/her representative, the Information and Assistance Officer shall aid the worker in procuring those records, reports and other information which are necessary for the identification to responsible employers and insurance carriers, and in obtaining information required by the Asbestos Workers' Account before payments may be made pursuant to Section 4406.

NOTE: Authority cited: Sections 5307.3 and 5451, Labor Code. Reference: Sections 139.6, 4410 and 5451, Labor Code.

HISTORY

1. New section filed 10-16-81; effective thirtieth day thereafter (Register 81, No. 42).

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§9929. Costs.

(a) Except as otherwise provided by this Section or by Section 5452 of the Labor Code, no fees or costs shall be charged to any party for services provided by the Division of Industrial Accidents under this Article.

(b) If the employee is represented, such representative may request that the Information and Assistance Officer refer the matter to a Workers' Compensation Judge for the determination of the value of the services of such representative. The Information and Assistance Officer shall, thereafter, refer such request to the Presiding Judge of the office which has jurisdiction over the claim.

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§9990. Fees for Transcripts; Copies of Documents; Certifications; Case File Inspection; Electronic Transactions

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The Division will charge and collect fees for copies of records or documents. For the purposes of this section, “records” includes any writing containing information relating to the conduct of the public's business which is prepared, owned, or used by the Division, regardless of the physical form or characteristics. “Writing” means handwriting, typewriting, printing, photostatting, photographing and every other means of recording any form of communication thereof, and all papers, maps, magnetic tapes, photographic films and prints, electronic facsimiles, any form of stored computer data, magnetic cards or disks, drums, and other documents.

Fees will be charged and collected by the Division as follows:

(a) For copies of papers, records or documents, not certified or otherwise authenticated, one dollar ($1.00) for the first copy and twenty cents ($0.20) for each additional copy of the same page, except to the injured worker to whom the fee will be ten cents ($.10) per page.

(1) State sales tax and postage will be added to this fee.

(b) For certification of copies of official records or documents and orders of evidence taken or proceedings had, ten dollars ($10.00) for each certification.

(1) Where the Division is requested to both copy and certify a document, the fee is the sum of the fees prescribed in (a) and (b) above.

(c) For paper transcripts of any testimony, three dollars ($3.00) for each page of the first copy of transcripts; thereafter, one dollar and fifty cents ($1.50) for each page of additional copies of the transcript.

(1) Sales tax and postage will be added to this fee.

(2) Transcripts delivered on a medium other than paper shall be compensated at the same rate set for paper transcripts, except an additional fee shall be charged to cover the cost of the medium and any copies thereof.

(d) For inspection of a case file not stored in the place where the inspection is requested, ten dollars ($10.00) plus any postage or other delivery costs, except when requested by an injured employee or his or her attorney or his or her representative of record.

(e) For electronic records maintained by the Division:

(1) Listing of WCAB new case filings:

(A) $305.00 per transmission for WCAB new case opening records transmitted to the requester on tape.

(B) $85.00 per download for WCAB new case opening records transmitted to the requester by direct electronic download.

Paper copies of the WCAB new case opening records provided in addition to the electronic data will be subject to a separate charge of $0.10 per page, plus postage.

(2) Electronic response to an electronic inquiry concerning a case's status, a lien's status, or other case specific information available in electronic form, through EDEX (the Division's Electronic Data Exchange program), twenty cents ($0.20) per transaction.

(3) The Division will provide electronic copies of WCAB new case opening records or EDEX access only pursuant to a written agreement with the administrative director.

(4) Copies of existing electronic records, other than those electronic records set forth in subsections (e)(1) or (e)(2), that constitute disclosable public records, will be provided as required by law, for the Division's actual costs of retrieving and transmitting the data, including programming and processing time, storage media, postage or shipping costs and sales tax. All programming and processing time required to create new data sorts of existing electronically maintained records will be charged at the Division's standard rate of $40.00 per hour, billed in fifteen (15) minute increments.

(f) Copies of Division records containing information that is privileged or otherwise non-disclosable will be redacted before release.

NOTE

Authority cited: Sections 127, 133, 138.7 and 5307.3, Labor Code. Reference: Sections 127 and 138.7, Labor Code.

HISTORY

1. Amendment of subsection (a) filed 11-7-78; effective thirtieth day thereafter (Register 78, No. 45). For former history, see Registers 77, No. 46; 75, No. 32; and 73, No. 51.

2. Amendment filed 8-29-84; effective thirtieth day thereafter (Register 84, No. 35).

3. Amendment of article and section headings and text filed 1-28-94; operative 1-28-94 (Register 94, No. 4). Submitted to OAL for printing only pursuant to Government Code section 11351.

4. Amendment of section and Note filed 8-22-2000; operative 9-21-2000 (Register 2000, No. 34).

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§9992. Payment of Fees in Advance.

Payment of fees in Section 9990 must accompany the request, either in cash or by check or money order made payable to the Division of Workers' Compensation, except as otherwise provided in the establishment of payment accounts.

NOTE: Authority cited: Sections 127, 133 and 5307.3, Labor Code. Reference: Section 127, Labor Code.

HISTORY

1. Amendment filed 1-28-94; operative 1-28-94 (Register 94, No. 4). Submitted to OAL for printing only pursuant to Government Code section 11351.

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§9994. Payment for Transcripts.

For transcripts of testimony or other proceeding of record, a deposit fee based on the number of paper pages, as estimated by the division, shall be paid by the requesting party in advance. If the actual fee exceeds the deposit, the purchaser will be notified of the balance to be paid prior to release of the transcripts or any copies. Any excess deposit will be returned to the purchaser.

NOTE: Authority cited: Sections 127, 133 and 5307.3, Labor Code. Reference: Section 127, Labor Code.

HISTORY

1. Amendment of section heading and text filed 1-28-94; operative 1-28-94 (Register 94, No. 4). Submitted to OAL for printing only pursuant to Government Code section 11351.

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§10001. Definitions. [Renumbered]

Note: Authority cited: Sections 133, 139.48 and 5307.3, Labor Code. Reference: Sections 139.48 and 4658.1, Labor Code; Henry v. WCAB (1998) 68 Cal.App.4th 981.

HISTORY

1. New section filed 6-30-2006; operative 7-1-2006. Submitted to OAL for filing with the Secretary of State and printing only pursuant to Government Codesection 11340.9(g) (Register 2006, No. 38). For prior history, see Register 96, No. 52.

2. Renumbering of former section 10001 to section 10116.9 filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§10002. Offer of Work; Adjustment of Permanent Disability Payments. [Renumbered]

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(4) The offer meets the conditions set forth in this section.

Note: Authority cited: Sections 133, 139.48 and 5307.3, Labor Code. Reference: Sections 139.48 and 4658, Labor Code; Del Taco v. WCAB (2000) 79 Cal.App.4th 1437; Anzelde v. WCAB (1996) 61 Cal. Comp. Cases 1458 (Writ denied); and Henry v. WCAB (1998) 68 Cal.App.4th 981.

HISTORY

1. New section filed 6-30-2006; operative 7-1-2006. Submitted to OAL for filing with the Secretary of State and printing only pursuant to Government Codesection 11340.9(g) (Register 2006, No. 38). For prior history, see Register 96, No. 52.

2. Renumbering of former section 10002 to section 10117 filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§10003. Form [DWC AD 10003 Notice of Offer of Work]. [Renumbered]

Note: Authority cited: Sections 133, 139.48 and 5307.3, Labor Code. Reference: Sections 139.48 and 4658, Labor Code.

HISTORY

1. New section filed 6-30-2006; operative 7-1-2006. Submitted to OAL for filing with the Secretary of State and printing only pursuant to Government Codesection 11340.9(g) (Register 2006, No. 38). For prior history, see Register 96, No. 52.

2. Renumbering of former section 10003 to section 10118 filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§10004. Return to Work Program. [Renumbered]

Note: Authority cited: Sections 133, 139.48 and 5307.3, Labor Code. Reference: Sections 62.5, 139.48 and 5814.6, Labor Code.

HISTORY

1. New article 12 (sections 10004-10005) and section filed 7-19-2006; operative 8-18-2006 (Register 2006, No. 29). For prior history of article 12 (sections 10001-10021), see Register 88, No. 21; Register 95, No. 7 and Register 96, No. 52.

2. Renumbering of former section 10004 to section 10119 filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§10005. Form [DWC AD 10005 Request for Reimbursement of Accommodation Expenses]. [Renumbered]

Note: Authority cited: Sections 133, 139.48 and 5307.3, Labor Code. Reference: Sections 62.5, 139.48 and 5814.6, Labor Code.

HISTORY

1. New section filed 7-19-2006; operative 8-18-2006 (Register 2006, No. 29).
For prior history, see Register 96, No. 52.

2. Renumbering of former section 10005 to section 10120 filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§10006. Notice to Employee. [Repealed]

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. Repealer and new section filed 5-17-88; operative 7-1-88 (Register 88, No. 21). For prior history, see Register 83, No. 30.

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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§10007. Reports to Bureau. [Repealed]

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. Repealer and new section filed 5-17-88; operative 7-1-88 (Register 88, No. 21). For prior history, see Register 83, No. 30.

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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§10007.1. Entitlement Issues [Repealed]

NOTE: Authority cited: Section 139.5, Labor Code. Reference: Section 133, Labor Code.

HISTORY

1. New section filed 6-15-81; effective thirtieth day thereafter (Register 81, No. 25).

2. Repealer filed 5-17-88; operative 7-1-88 (Register 88, No. 21).

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§10008. Identification of Need for Vocational Rehabilitation Services. [Repealed]

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. Repealer and new section filed 5-17-88; operative 7-1-88 (Register 88, No. 21). For prior history, see Register 83, No. 30.

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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§10009. Initiation of Vocational Rehabilitation Services [Repealed]

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. Repealer and new section filed 5-17-88; operative 7-1-88 (Register 88, No. 21). For prior history, see Register 79, No. 30.

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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§10010. Independent Vocational Evaluators [Repealed]

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. Repealer and new section filed 5-17-88; operative 7-1-88 (Register 88, No. 21). For prior history, see Register 75, No. 1.

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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§10011. Vocational Rehabilitation Plans [Repealed]

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. Repealer and new section filed 5-17-88; operative 7-1-88 (Register 88, No. 21). For prior history, see Register 83, No. 30.

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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§10012. Plan Approval [Repealed]

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. Repealer and new section filed 5-17-88; operative 7-1-88 (Register 88, No. 21). For prior history, see Register 79, No. 30.

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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§10013. Entitlement Issues [Repealed]

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. Repealer and new section filed 5-17-88; operative 7-1-88 (Register 88, No. 21). For prior history, see Register 83, No. 30.

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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§10014. Bureau Resolution of Disputes [Repealed]

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. Repealer and new section filed 5-17-88; operative 7-1-88 (Register 88, No. 21). For prior history, see Register 79, No. 30.

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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§10016. Conclusion of Vocational Rehabilitation Services [Repealed]

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. Repealer and new section filed 5-17-88; operative 7-1-88 (Register 88, No. 21). For prior history, see Register 83, No. 30.

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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§10017. Reinstatement of Vocational Rehabilitation Benefits [Repealed]

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. Repealer and new section filed 5-17-88; operative 7-1-88 (Register 88, No. 21). For prior history, see Register 83, No. 30.

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 12. Vocational Rehabilitation

New query

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§10018. Vocational Rehabilitation Temporary Disability Indemnity [Repealed]

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. New section filed 5-17-88; operative 7-1-88 (Register 88, No. 21).

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 12. Vocational Rehabilitation

New query

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§10019. Bureau File Retention

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. New section filed 5-17-88; operative 7-1-88 (Register 88, No. 21).

2. Renumbering and amendment of former section 10019 to section 10134 filed 2-16-95; operative 2-16-95. Submitted to OAL for printing only pursuant to Government Code § 11351 (Register 95, No. 7).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 12. Vocational Rehabilitation

New query

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§10020. Enforcement of Notice and Reporting Requirements

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. New section filed 5-17-88; operative 7-1-88 (Register 88, No. 21).

2. Repealer of section filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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Chapter 4.5. Division of Workers' Compensation
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New query

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§10021. Rehabilitation of Industrially Injured Inmates.

NOTE: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Chapter 1435, 1974 Stats.

HISTORY

1. New section filed 5-17-88; operative 7-1-88 (Register 88, No. 21).

2. Renumbering of former section 10021 to new section 10133.4 filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 1. Audit, General Definitions

New query

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§10100. Definitions--Prior to January 1, 1994.

The following definitions apply in Articles 1 through 7 of this Subchapter for injuries occurring on or after January 1, 1990 and before January 1, 1994.
(a) Adjusting Location. The office where claims are administered.

(b) Administrative Director. The Administrative Director of the Division of Workers' Compensation or his/her duly authorized representative.

(c) Audit. Any audit performed by the Audit Unit of the Division of Workers' Compensation pursuant to Labor Code Sections 129 and 129.5.

(d) Claims Administrator. A self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(e) Claim File. A record, either in legible paper or electronic form which can be produced into legible paper, containing all of the information specified in Section 10101 and related documents pertaining to a given work-injury claim.

(f) Claim Log. A handwritten or printed ledger maintained by the claims administrator listing each work injury case by the date the injury was reported to the claims administrator and listing the date of injury. The claim log contents are specified in Section 10103.

(g) Compensation. Compensation as defined in Labor Code Section 3207.

(h) Duly Authorized Representative. A designated employee or unit of the Department of Industrial Relations.
(i) DWC. The Division of Workers' Compensation of the Department of Industrial Relations.

(j) Employee. An employee, his or her dependents or his agent.

(k) Indemnity Case. A work-injury claim which has or may result in any of the following benefits:

(1) Temporary Disability

(2) Permanent Disability

(3) Life Pension

(4) Death Benefits

(5) Vocational Rehabilitation

(l) Insurer. Any company, group or entity in, or which has been in, the business of transacting workers' compensation insurance for employers subject to the workers' compensation laws of this state. The term insurer includes the State Compensation Insurance Fund.

(m) Investigation. The process of examining and evaluating a claim to determine the nature and extent of all legally required benefits, if any, which are due under the claim. Investigation may include formal or informal methods of gathering information relevant to evaluating the claim such as: obtaining employment records, obtaining earnings records, informal or formal interviews of the employee, employer, or witnesses, deposition of parties or witnesses, obtaining expert opinion where an issue requires an expert opinion for its resolution, such as obtaining a medical-legal evaluation.

(n) Issue Date. The date upon which a notice of penalty assessment or an order of the Administrative Director is served.

(o) Joint Powers Authority. Any county, city, city and county, municipal corporation, public district, public agency, or political subdivision of the state, but not the state itself, including in a pooling arrangement under a joint exercise of powers agreement for the purpose of securing a certificate of consent to self-insure workers' compensation claims under Labor Code Section 3700(c).

(p) Medical-Only Claim. A work-injury case which requires compensation only for medical treatment by a physician.

(q) Medical Fee Schedule. Official schedule promulgated by the Administrative Director pursuant to Labor Code Section 5307.1. Refer to Title 8 of existing CCR Section 9791.1 through Section 9792.

(r) Non-Random. Any method of selecting an audit subject which is specific to that audit subject, based on any or all of the factors provided in Labor Code Section 129(b).

(s) Notice of Compensation Due. The Notice of Assessment issued pursuant to Labor Code Section 129(c).

(t) Open Claim. A work-injury claim in which future payment of compensation may be due or for which reserves for the future payment of compensation are maintained.

(u) Payment Schedule. The two-week cycle of indemnity payments due on the day designated with the first

payment as required by Labor Code Section 4650(c) or 4702(b).

(v) Random. Any method of selecting an audit subject which is not based on factors specific to that audit subject, but instead which chooses subjects from a broad cross-section of possible subjects. Random selection methods may stratify by general groups and need not be statistically precise.

(w) Self-insured Employer. An employer that has been issued a certificate of consent to self-insure as provided by Labor Code Section 3700(b) or (c), including a joint powers authority or the State of California as a legally uninsured employer.

(x) Third-Party Administrator. An agent under contract to administer the workers' compensation claims of an insurer, self-insured employer, or joint powers authority.

(y) VRMA. Vocational rehabilitation maintenance allowance.

(z) Work-Injury Claim. A claim for an injury that is reported or reportable to the Division of Labor Statistics and Research pursuant to Sections 6409, 6409.1 and 6413 of the Labor Code.

Note: Authority cited: Sections 59, 133, 129.5, 138.4 and 5307.3, Labor Code. Reference: Sections 7, 124, 129, 129.5, 3700, 3702.1, 4636, 4650(c), 5307.1 and 5402, Labor Code.

HISTORY

1. New section filed 1-18-90; operative 1-18-90 (Register 90, No. 4). New section is exempt from review by OAL pursuant to Government Code Section11351.

2. Amendment of section heading, text and Note filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section11351 (Register 94, No. 4).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 1. Audit, General Definitions

New query

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§10100.1. Definitions--On or After January 1, 1994.

The following definitions apply in Articles 1 through 7 of this Subchapter for injuries occurring on or after January 1, 1994.
(a) Adjusting Location. The office where claims are administered.

(b) Administrative Director. The Administrative Director of the Division of Workers' Compensation or the Director's duly authorized representative, designee, or delegee.

(c) Audit. An audit performed under Labor Code Sections 129 and 129.5.

(d) Audit Subject. A single adjusting location of a claims administrator which has been selected for audit. If a claims administrator has more than one adjusting location, other locations may be selected as separate audit subjects. In its discretion, the Audit Unit may combine more than one adjusting location of a claims administrator as a single non-random audit subject.

(e) Audit Unit. The organizational unit within the Division of Workers' Compensation which audits insurers, self-insured employers and third-party administrators pursuant to Labor Code Sections 129 and 129.5.

(f) Claim. A request for compensation for an injury arising out of and in the course of employment, whether disputed or not, or notice or knowledge that such an injury has occurred or is alleged to have occurred.

(g) Claim File. A record in paper or electronic form, or a combination, containing all of the information specified in Section 10101.1 of these Regulations and all documents or entries related to the provision or denial of benefits.
(h) Claim Log. A handwritten or printed ledger maintained by the claims administrator listing each work-injury claim as specified in Section 10103.1 of these Regulations.

(i) Claims Administrator or Administrator. A self-administered workers' compensation insurer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, or a third-party claims administrator for an insurer, a self-insured employer, a legally-uninsured employer or a joint powers authority.

(j) Closed Claim. A work-injury claim in which future payment of compensation cannot be reasonably expected to be due.

(k) Compensation. Every benefit or payment, including vocational rehabilitation, medical, and medical-legal expenses, conferred by Divisions 1 and 4 of the Labor Code on an injured employee or the employee's dependents.

(l) Date of Knowledge of Injury and Disability. The date the employer had knowledge or reasonably can be expected to have had knowledge of (1) a worker's injury or claim for injury, and (2) the worker's inability or claimed inability to work because of the injury.

(m) Denied Claim. A claim for which all liability has been denied at any time, even if the claim was accepted before or after the denial. A claim which otherwise meets this definition is a denied claim even if medical-legal expenses were paid.

(n) Employee. An employee, or in the case of the employee's death, his or her dependent, as each is defined in Division 4 of the Labor Code, or the employee's or dependent's agent.

(o) First Payment of Temporary Disability Indemnity. (1) The first payment of temporary disability indemnity made to an injured worker for a work injury; or (2) the first resumed payment of temporary disability indemnity following any period of one or more days for which no temporary disability indemnity was payable for that work injury; or (3) the first resumed payment of temporary disability indemnity following issuance of a lawful notice that temporary disability benefits were ending.

(p) Indemnity Claim. A work-injury claim which has resulted or may result in entitlement to any of the following benefits: temporary disability indemnity or salary continuation in lieu of temporary disability indemnity, permanent disability indemnity, death benefits, or vocational rehabilitation.

(q) Insurer. Any company, group, or entity in, or which has been in, the business of transacting workers' compensation insurance for employers subject to the workers' compensation laws of this state. The term insurer includes the State Compensation Insurance Fund.

(r) Investigation. The process of examining and evaluating a claim to determine the nature and extent of all legally required benefits, if any, which are due under the claim. Investigation may include formal or informal methods of gathering information relevant to evaluating the claim such as: obtaining employment records; obtaining earnings records; informal or formal interviews of the employee, employer, or witnesses; deposition of parties or witnesses; obtaining expert opinion where an issue requires an expert opinion for its resolution, such as obtaining a medical-legal evaluation.

(s) Joint Powers Authority. Any county, city, city and county, municipal corporation, public district, public agency, or political subdivision of the state, but not the state itself, included in a pooling arrangement under a joint exercise of powers agreement for the purpose of securing a certificate of consent to self-insure workers' compensation claims under Labor Code Section 3700(c).

(t) Medical-Only Claim. A work-injury claim in which no indemnity benefits are payable.

(u) Non-Random. Any method of selecting an audit subject which is specific to that audit subject, based on any or all of the factors provided in Labor Code Section 129(b).

(v) Notice of Compensation Due. The Notice of Assessment issued pursuant to Labor Code Section 129(c).

(w) Open Claim. A work-injury claim in which future payment of compensation may be due or for which reserves for the future payment of compensation are maintained.

(x) Payment Schedule. Either:

(1) The two-week cycle of indemnity payments due on the day designated with the first payment as required by Labor Code Section 4650(c) or 4702(b), including any lawfully changed payment schedule; or

(2) The two-week cycle of payments of vocational rehabilitation maintenance allowance (VRMA) required by Title 8, California Code of Regulations, Division 1, Chapter 4.5, Subchapter 1.5, Article 7, Section 10125.1.

(y) Random. Any method of selecting an audit subject which is not based on factors specific to that audit subject, but instead which chooses subjects from a broad cross-section of possible subjects. Random selection methods may stratify by general groups and need not be statistically precise.

(z) Record of Payment. An accurate written or electronic record of all compensation payments in a claim file, including but not limited to:

(1) The check number, date the check was issued, name of the payee, amount, and for indemnity payments the time period(s) covered by the payment;

(2) All dates for which salary continuation as defined by Labor Code Section 4650(g) was provided instead of direct indemnity payments; the dates for which salary continuation was authorized; and documentation when applicable that sick leave or other leave credits were restored for any periods for which salary continuation was payable;

(3) A copy of each bill received which included a medical progress or work status report; and either a copy of each other bill received or documentation of the contents of that bill showing the date and description of the service provided, provider's name, amount billed, date the claims administrator received the bill, and date and amount paid.

(aa) Self-insured Employer. An employer, either as an individual employer or as a group of employers, that has been issued a certificate of consent to self-insure as provided by Labor Code Section 3700(b) or (c), including a joint powers authority or the State of California as a legally uninsured employer.

(bb) Third-Party Administrator. An agent under contract to administer the workers' compensation claims of an insurer, self-insured employer, or joint powers authority.

(cc) VRMA. Vocational rehabilitation maintenance allowance.

Note: Authority cited: Sections 59, 133, 129.5, 138.4, 5307.3, Labor Code. Reference: Sections 7, 124(a), 129(a), (b), (c), 129.5(a), (b), 3700, 3702.1, 4636, 4650(c), 5307.1, 5402, Labor Code.

HISTORY

1. New section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

2. Amendment of subsection (i) filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

3. Editorial correction of subsection (d) (Register 2000, No. 45).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 1. Audit, General Definitions

New query

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§10100.2. Definitions

The following definitions apply in Articles 1 through 7 of this Subchapter for audits conducted on or after January 1, 2003.

(a) Adjusting Location. The office where claims are administered. Separate underwriting companies, self-administered, self-insured employers, and/or third-party administrators operating at one location shall be combined as one audit subject for the purposes of audits conducted pursuant to Labor Code section 129(b) only if claims are administered under the same local management at that location.

For auditing purposes, any separate office or location whose staff includes local management may be considered a single adjusting location.

(b) Additional claim file. A claim selected for audit in addition to the random sample of claims selected. An additional claim file may include a companion claim file, a file selected for audit because it was incorrectly designated on the claim log, or a claim chosen based on criteria relevant to a target audit but for which no specific complaint has been received.

(c) Administrative Director. The Administrative Director of the Division of Workers' Compensation or the Director's duly authorized representative, designee, or delegee.

(d) Audit. An audit performed under Labor Code sections 129 and 129.5.

(e) Audit Subject. A single adjusting location of a claims administrator which has been selected for audit. If a claims administrator has more than one adjusting location, other locations shall be considered as separate audit subjects for the purposes of implementing Labor Code sections 129(a) and 129(b). However, the Audit Unit at its discretion may combine more than one adjusting location of a claims administrator as a single targeted audit subject, or may designate one insurer, insurer group, or self-insured employer at one or more third-party administrator adjusting locations as a single targeted audit subject.

(f) Audit Unit. The organizational unit within the Division of Workers' Compensation which audits and/or investigates insurers, self-insured employers and third-party administrators pursuant to Labor Code sections 129 and 129.5.

(g) Carve-Out Program.

(1) An alternative dispute resolution (ADR) system for employees and employers engaged in construction (or other enumerated activities), established pursuant to Labor Code section 3201.5.

(2) An alternative dispute resolution (ADR) system for any industry (other than construction), established pursuant to Labor Code section 3201.7.

(h) Claim. A request for compensation, or record of an occurrence in which compensation reasonably would be expected to be payable for an injury arising out of and in the course of employment.

(i) Claim File. A record in paper or electronic form, or a combination, containing all of the information specified in California Code of Regulations, title 8, section 10101.1 and all documents or entries related to the provision, delay, or denial of benefits.

(j) Claim Log. A handwritten, printed, or electronically maintained listing maintained by the claims administrator listing each work-injury claim as specified in California Code of Regulations, title 8, section 10103.2.

(k) Claims Administrator or Administrator. A self-administered workers' compensation insurer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, or a third-party claims administrator for an insurer, a self-insured employer, a legally-uninsured employer or a joint powers authority.

(l) Closed Claim. A work-injury claim in which future payment of compensation cannot be reasonably expected to be due.

(m) Companion claim file. A claim file that is related to a claim file selected for random or targeted audit, in that claims were filed by the same injured worker, and the Audit Unit cannot ascertain the extent to which benefits have been paid on the initial claim selected for audit without auditing the related claim file.

(n) Compensation. Every benefit or payment, including vocational rehabilitation, supplemental job displacement benefits, medical treatment, and medical-legal expenses, conferred by Divisions 1 and 4 of the Labor Code on an injured employee or the employee's dependents.

(o) Complaint claim file. A claim file that is selected for audit because the Audit Unit has received information indicating the existence of possible claims handling violations of the kind which, if found, would be subject to the assessment of an administrative penalty, the issuance of a notice of compensation due, or the assessment of a civil penalty.

(p) Date of Knowledge of Injury and Disability. The date the employer had knowledge or reasonably can be expected to have had knowledge, pursuant to Labor Code section 5402, of (1) a worker's injury or claim for injury, and (2) the worker's inability or claimed inability to work because of the injury.
(q) Denied Claim. A claim for which all liability has been denied at any time, even if the claim was accepted before or after the denial. A claim which otherwise meets this definition is a denied claim even if medical treatment is provided and paid pursuant to Labor Code section 5402(c) or medical-legal expenses were paid.

(r) Employee. An employee, or in the case of the employee's death, his or her dependent, as each is defined in Division 4 of the Labor Code, or the employee's or dependent's agent.

(s) First Payment of Permanent Disability Indemnity. (1) The first payment of permanent disability indemnity made to an injured worker for a work injury; or (2) the resumed payment of permanent disability indemnity following any period of one or more days for which no permanent disability indemnity was payable for that work injury; or (3) the resumed payment of permanent disability indemnity following issuance of a lawful notice that permanent disability benefits were ending.

(t) First Payment of Temporary Disability Indemnity. (1) The first payment of temporary disability indemnity made to

an injured worker for a work injury; or (2) the resumed payment of temporary disability indemnity following any period of one or more days for which no temporary disability indemnity was payable for that work injury; or (3) the resumed payment of temporary disability indemnity following issuance of a lawful notice that temporary disability benefits were ending.

(u) First Payment of Vocational Rehabilitation Maintenance Allowance. (1) The first payment of Vocational Rehabilitation Maintenance Allowance made to an injured worker for a work injury; or (2) the resumed payment of Vocational Rehabilitation Maintenance Allowance following any period of one or more days for which no Vocational Rehabilitation Maintenance Allowance was payable for that work injury; or (3) the resumed payment of Vocational Rehabilitation Maintenance Allowance following issuance of a lawful notice that Vocational Rehabilitation Maintenance Allowance benefits were ending.

(v) Frequency. The ratio of the number of claim files with one or more of a specific type of violation divided by the number of claim files with exposure for the same specific type of violation selected for audit at the adjusting location.

(w) General Business Practice. For the purposes of Labor Code section 129.5(e), conduct that can be distinguished by a reasonable person from an isolated event. The conduct can include a single practice and/or separate, discrete acts or omissions in the handling of several claims.

(x) Indemnity Claim. A work-injury claim that has resulted in the payment of any of the following benefits: temporary disability indemnity, including temporary partial disability indemity, or salary continuation in lieu of temporary disability indemnity, permanent disability indemnity, death benefits, or vocational rehabilitation maintenance allowance.

(y) Indemnity Payment. Compensation for any of the following benefits: temporary disability indemnity, including temporary partial disability indemnity, or salary continuation in lieu of temporary disability indemnity, permanent disability indemnity, death benefits, or vocational rehabilitation maintenance allowance. An indemnity payment includes any increase made pursuant to Labor Code section 4650(d), and any interest pursuant to Labor Code section 5800.

(z) Insurer. Any company, group, or entity in, or which has been in, the business of transacting workers' compensation insurance for employers subject to the workers' compensation laws of this state. The term insurer includes the State Compensation Insurance Fund.

(aa) Investigation.

(1) As conducted by a claims administrator, an investigation is the process of examining and evaluating a claim to determine the nature and extent of all legally required benefits, if any, which are due under the claim. Investigation may include formal or informal methods of gathering information relevant to evaluating the claim such as: obtaining employment records; obtaining earnings records; informal or formal interviews of the employee, employer, or witnesses; deposition of parties or witnesses; and, obtaining expert opinion where an issue requires an expert opinion for its resolution, such as obtaining a medical-legal evaluation.

(2) As conducted by the Audit Unit, an investigation is the process of reviewing and evaluating, pursuant to California Code of Regulations, title 8, section 10106.5 and/or Government Code sections 11180 through 11191, the extent to which a claims administrator meets its compensation obligations under the California Labor Code or Administrative Director's regulations. An investigation may be conducted concurrently as part of an on-going audit without separate notice issued by the Audit Unit, or may be conducted independently from a specific audit in order to determine if an audit will be conducted, or to determine the nature and extent of business practices for which one or more civil penalties may be assessed pursuant to Labor Code section 129.5(e).

(bb) Joint Powers Authority. Any county, city, city and county, municipal corporation, public district, public agency, or

political subdivision of the state, but not the state itself, included in a pooling arrangement under a joint exercise of powers agreement for the purpose of securing a certificate of consent to self-insure workers' compensation claims under Labor Code section 3700(c).

(cc) Knowingly committed. Acting with knowledge of the facts of the conduct subject to an investigation and/or audit under Labor Code sections 129 and 129.5. A corporation has knowledge of facts any employee receives while acting within the scope of his or her authority. A corporation has knowledge of information contained in its records and of the actions of its employees performed in the course of employment. An employer or insurer has knowledge of information contained in the records of its third party administrator and of the actions of the employees of the third party administrator performed in the scope and course of employment.
(dd) Lawful delay. A delay permitted by law or regulation, and for which the claims administrator has given a proper and timely notice of delay when such a notice is required. Any other delay is an unlawful delay.

(ee) Local Management. Claims personnel, regardless of their job titles, who have supervisory authority at an adjusting location over claims administration.

(ff) Medical-Only Claim. A work-injury claim in which no indemnity benefits have been paid or would reasonably be anticipated or expected to be paid.

(gg) Nontransferable Training Voucher. A document provided to an employee that allows the employee to enroll in education-related training or skills enhancement. The document shall include identifying information for the employee and claims administrator, and specific information regarding the value of the voucher pursuant to Labor Code section 4658.5 and California Code of Regulations, title 8, section 10133.50 et seq.

(hh) Notice of Compensation Due. The Notice of Assessment issued pursuant to Labor Code section 129(c).

(ii) Open Claim. A work-injury claim in which future payment of compensation may be due or for which reserves for the future payment of compensation are maintained.

(jj) Payment Schedule. Either:

(1) The two-week cycle of indemnity payments due on the day designated with the first payment as required by Labor Code sections 4650(c) or 4702(b), including any lawfully changed payment schedule; or

(2) The two-week cycle of payments of vocational rehabilitation maintenance allowance (VRMA) required by California Code of Regulations, title 8, section 10125.1.

(kk) Performance Standard. Criteria developed from historical audit findings data and used as a basis for judgment of quality, quantity, level, and grade to measure claim adjusting performance in the handling of the workers' compensation benefit areas set forth in California Code of Regulations, title 8, section 10107.1, subdivision (c)(3)(A). The standard rating factors will be calculated annually and based on all final audit findings as published in the Annual DWC Audit Reports over the three calendar years before the year preceding the current audit. The Administrative Director shall determine and publish the performance standards for profile audit reviews and full compliance audits for the following calendar year.

(ll) Random sample. For the purpose of audit or investigation, a random sample is a selection of claim files selected pursuant to California Code of Regulations, title 8, section 10107.1, subdivisions (c)(1), (d)(1) or (e)(1).

(mm) Record of Payment. An accurate written or electronic record of all compensation payments in a claim file, including but not limited to:

(1) The check number, date the check was issued, name of the payee, amount, and for indemnity payments,

including self-imposed increases, penalties, and/or interest, the time period(s) covered by the payment;

(2) All dates for which salary continuation as defined by Labor Code section 4650(g) was provided instead of direct indemnity payments; the dates for which salary continuation was authorized; and documentation when applicable that sick leave or other leave credits were restored for any periods for which salary continuation was payable;

(3) A copy of each bill received which included as part of the bill a medical progress or work status report; and either a copy of each other bill received or documentation of the contents of that bill showing the date and description of the service provided, provider's name, amount billed, date the claims administrator received the bill, the number of the check providing payment for each bill, including the check number, the date of the check, and the amount paid.

(nn) Self-insured Employer. An employer, either as an individual employer or as a group of employers, that has been issued a certificate of consent to self-insure as provided by Labor Code section 3700(b) or (c), including a joint powers authority or the State of California as a legally uninsured employer.

(oo) Supplemental Job Displacement Benefit. An educational retraining or skills enhancement allowance for injured employees, with dates of injury on or after January 1, 2004, whose employers are unable to provide work consistent with the requirements of Labor Code sections 4658.5 and California Code of Regulations, title 8, section 10133.50 et seq.

(pp) Third-Party Administrator. An agent under contract to administer the workers' compensation claims of an insurer, a self-insured employer, a legally uninsured employer. or a self-insured joint powers authority. The term third-party administrator includes the State Compensation Insurance Fund for locations that administer claims for legally uninsured and self-insured employers, and also includes Managing General Agents.

(qq) VRMA. Vocational rehabilitation maintenance allowance.

(rr) Workers' Compensation Information System (WCIS). The workers' compensation information system established pursuant to Labor Code sections 138.6 and 138.7.

Note: Authority cited: Sections 59, 129, 129.5, 133, 138.4 and 5307.3, Labor Code. Reference: Sections 7, 124(a), 129(a), 129(b), 129(c), 129.5(a), 129.5(b), 138.6, 138.7, 139.5, 3700, 3702.1, 4636, 4650(c), 4658.5, 4658.6, 5307.1 and 5402, Labor Code.

HISTORY

1. New section filed 12-30-2002; operative 1-1-2003 pursuant to GovernmentCode section 11343.4 (Register 2003, No. 1).

2. Amendment of section and Note filed 4-20-2009; operative 5-20-2009 (Register 2009, No. 17).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 2. Claims Administration and Recordkeeping

New query

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§10101. Claim File--Contents.

This section applies to maintenance of claims files for injuries occurring before January 1, 1994.
Every claims administrator shall maintain a claim file of each work-injury claim including claims which were denied. All open claim files shall be kept at the adjusting location for the file. The file shall contain but not be limited to:
(a) An employer date stamped copy of the Employee's Claim for Workers' Compensation Benefits, DWC Form 1, or documentation of reasonable attempts to obtain the form.

(b) Employers Report of Occupational Injury or Illness, DLSR Form 5020, or documentation of reasonable attempts to obtain it.

(c) Every notice or report sent to the Division of Workers' Compensation.

(d) A copy of every Doctor's First Report of Occupational Injury or Illness, DLSR Form 5021, or documentation of reasonable attempts to obtain them.

(e) The original or a copy of every medical report pertaining to the claim, or documentation of reasonable attempts to obtain them.

(f) All orders or awards of the Workers' Compensation Appeals Board pertaining to the claim.

(g) A record of payment of compensation.

(h) A copy of the application(s) for adjudication of claim filed with the Workers' Compensation Appeals Board, if any.

(i) Copies of all notices sent to the employee pursuant to the requirements of the Benefit Notice Program established by Labor Code Section 138.4 and the notices required by Article 2.6 of Chapter 2 of Part 2 of the Labor Code, commencing with Section 4635.

Note: Authority cited: Sections 59, 129.5, 133, 138.4, 4603.5 and 5307.3, Labor Code. Reference: Sections 124, 129, 129.5, 138.3, 138.4, 139.5, 4061, 4453, 4454, 4600, 4603.2, 4621, 4622, 4636, 4637, 4641, 4643, 4644, 4650, 4701 through 4703.5, 5401, 6409 and 6409.1, Labor Code.

HISTORY

1. New section filed 1-18-90; operative 1-18-90 (Register 90, No. 4). New section is exempt from review by OAL pursuant to Government Code Section11351.

2. Amendment of article heading, section heading, text and N ote filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 2. Claims Administration and Recordkeeping

New query

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§10101.1. Claim File--Contents.

This section applies to maintenance of claim files for injuries occurring on or after January 1, 1994.

Every claims administrator shall maintain a claim file of each work-injury claim including claims which were denied. For injuries reported on or after June 19, 2009 each claims administrator shall maintain a claim file for each indemnity and medical-only claim, including denied claims, and shall ensure that each file is complete and current for each claim. Contents of claim files may be in hard copy, in electronic form, or some combination of hard copy and electronic form. Files maintained in hard copy shall be in chronological order with the most recently dated documents on top, or subdivided into sections such as medical reports, benefit notices, correspondence, claim notes, and vocational rehabilitation. Files or portions of files maintained in electronic form shall be easily retrievable. All open claim files shall be maintained at the adjusting location responsible for administering the claim. The file shall contain but not be limited to:

(a) Either (1) a copy of the Employee's Claim for Workers' Compensation Benefits, DWC Form 1, showing the employer's date of knowledge of injury, the date the employer provided the form to the employee and the date the employer received the completed form from the employee; or (2) if the employee did not return the claim form, documentation of the date the employer provided a claim form to the employee. If the administrator cannot obtain the form or determine that the form was provided to the employee by the employer, the file shall contain documentation that the administrator has provided the claim form to the employee as required by Title 8, California Code of Regulations section 10119.

(b) A copy of the Employer's Report of Occupational Injury or Illness, DLSR Form 5020, or documentation of reasonable attempts to obtain it;

(c) A copy of every notice, correspondence either initiated or received by the claims administrator, or report sent to the Division of Workers' Compensation.

(d) A copy of every Doctor's First Report of Occupational Injury or Illness, DLSR Form 5021, or documentation of reasonable attempts to obtain them.

(e) The original or a copy of every medical report pertaining to the claim, or documentation of reasonable attempts to obtain them.

(f) All orders or awards of the Workers' Compensation Appeals Board or the Rehabilitation Unit pertaining to the claim.

(g) A record of payment of compensation.

(h) A copy of the application(s) for adjudication of claim filed with the Workers' Compensation Appeals Board, if any.

(i) Copies of the following notices sent to the employee:

(1) Benefit notices, including vocational rehabilitation notices and supplemental job displacement benefit notices, required by California Code of Regulations, title 8, section 9810, or by California Code of Regulations, title 8, section 10122 through section 10133.60;

(2) Notices and forms related to the Qualified Medical Evaluation or Agreed Medical Evaluator process required by Labor Code sections 4060 et seq.;

(j) Documentation sufficient to determine the injured worker's average weekly earnings in accordance with Labor Code sections 4453 through 4459. Unless the claims administrator accepts liability to pay the maximum temporary disability rate, including any increased maximum due under Labor Code section 4661.5, the information shall include:

(1) Documentation whether the employee received the following earnings, and if so, the amount or fair market value of each: tips, commissions, bonuses, overtime, and the market value of board, lodging, fuel, or other advantages as part of the worker's remuneration, which can be estimated in money, said documentation to include the period of time, not exceeding one year, as may conveniently be taken to determine an average weekly rate of pay;

(2) Documentation of concurrent earnings from employment other than that in which the injury occurred, or that there were no concurrent earnings, or of reasonable attempts to determine this information;

(3) If earnings at the time of injury were irregular, documentation of earnings from all sources of employment for one year prior to the injury, or of reasonable attempts to determine this information.

(4) If the foregoing information results in less than maximum earnings, documentation of the worker's earning capacity, including documentation of any increase in earnings likely to have occurred but for the injury (such as periodic salary increases or increased earnings upon completion of training status), or of reasonable attempts to determine this information.

(k) Notes, correspondence, and documentation, including correspondence to or from any individual or entity, related to the provision, delay, or denial of benefits.

(l) Notes, correspondence, and documentation, including correspondence to or from any individual or entity, related to any utilization review process conducted under Labor Code section 4610.

(m) Notes, correspondence, and documentation, including correspondence to or from any individual or entity, related to a return to regular, modified, or alternative work as defined by Labor Code section 4658.1

(n) Notes, correspondence, and documentation, including correspondence to or from any individual or entity, evidencing the legal, factual, or medical basis for non-payment or delay in payment of compensation benefits or expenses.

(o) Notes, correspondence, and documentation, including correspondence to or from any individual or entity, describing telephone conversations relating to the claim which are of significance to claims handling, including the dates of calls, substance of calls, and identification of parties to the calls.

Note: Authority cited: Sections 59, 129.5, 133, 138.4, 4603.5 and 5307.3, Labor Code. Reference: Sections 124, 129, 129.5, 138.3, 138.4, 139.48, 139.5, 4060, 4061, 4062, 4453, 4454, 4600, 4603.2, 4616, 4621, 4622, 4636, 4637, 4641, 4643, 4644, 4650, 4658.5, 4658.6, 4701-4703.5, 5401, 6409 and 6409.1, Labor Code.

HISTORY

1. New section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

2. Amendment of section and Note filed 4-20-2009; operative 5-20-2009 (Register 2009, No. 17).

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Subchapter 1.5. Injuries on or After January 1, 1990
Article 2. Claims Administration and Recordkeeping

New query

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§10102. Retention of Claim Files.

(a) All claim files shall be maintained at least until the latest of the following dates:

(1) five years from the date of injury;

(2) one year from the date compensation was last provided;

(3) all compensation due or which may be due has been paid;

(4) if an audit has been conducted within the time specified in (a)(1), until the findings of an audit of the file have become final.

(b) Open and closed claim files may be maintained in whole or in part in an electronic or other non-paper storage medium.

Note: Authority cited: Sections 59, 129.5(b), 133, 138.4, 4603.5 and 5307.3, Labor Code. Reference: Sections 124(a), 129(a) through (c), 129.5(a), (b), (d), 138.3, 4061, 4453, 4454, 4600, 4603.2(b), 4621, 4622, 4636, 4637, 4641, 4643, 4644, 4650, 4701 through 4703.5, 5401(a), 5401.6, 5405 and 5804, Labor Code.

HISTORY

1. New section filed 1-18-90; operative 1-18-90 (Register 90, No. 4). New section is exempt from review by OAL pursuant to Government Code Section11351.

2. Renumbering of former section 10103 to section 10102, and renumbering and amendment of former section 10102 to section 10103 filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Codesection 11351 (Register 94, No. 4).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 2. Claims Administration and Recordkeeping

New query

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§10103. Claim Log--Contents and Maintenance.

This section shall govern claim log maintenance prior to January 1, 1994.
(a) Every claims administrator shall produce a claim log of all work-injury claims maintained at each adjusting location, prepared chronologically in alphanumeric or numeric ascending order, or in a combination thereof.

(b) The claim log shall contain at least the following information:

(1) Name of injured.

(2) The claims administrator's claim number.

(3) Date of injury.

(4) An indication as to whether the work-injury claim is an indemnity or medical-only case.

(5) An entry if all liability for a claim has been denied.

(6) For self-insurer, when a Certificate of Consent to Self-Insure has been issued, an entry identifying the corporation employing the injured.

(c) The claim log of a former self-insurer shall be maintained and made available to the audit unit within 5 days of request.

(d) A claims administrator shall provide a copy of a claim log within 14 days of receiving a written request from the Administrative Director.

Note: Authority cited: Sections 59, 129.5, 133 and 5307.3, Labor Code. Reference: Sections 124, 129, 129.5, 138.4, 3702.8 and 5401, Labor Code.

HISTORY

1. New section filed 1-18-90; operative 1-18-90 (Register 90, No. 4). New section is exempt from review by OAL pursuant to Government Code Section11351.

2. Renumbering of former section 10102 to section 10103, and renumbering and amendment of former section 10103 to section 10102 filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Codesection 11351 (Register 94, No. 4).

3. Amendment of subsection (b)(6) filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

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Subchapter 1.5. Injuries on or After January 1, 1990
Article 2. Claims Administration and Recordkeeping

New query

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§10103.1. Claim Log--Contents and Maintenance.

This section shall govern claim log maintenance on or after January 1, 1994.
(a) The claims administrator shall maintain annual claim logs listing all work-injury claims, open and closed. Each year's log shall be maintained for at least five years from the end of the year covered. Separate claim logs shall be maintained for each self-insured employer and each insurer for each adjusting location.

(b) Each entry in the claim log shall contain at least the following information:

(1) Name of injured worker.

(2) Claims administrator's claim number.

(3) Date of injury.

(4) An indication whether the claim is an indemnity or medical-only claim.

(5) An entry if all liability for a claim has been denied at any time. All liability is considered to have been denied even if the administrator accepted liability for medical-legal expense.

(6) If the claim log is for a self-insured employer and a Certificate of Consent to Self-Insure has been issued, the name of the corporation employing the injured worker. If the claim log consists of claims for two or more members of an insurer group, each entry on the log shall identify the insurer.

(c) The entries on a log provided to the Administrative Director shall reflect current information, to show at least any changes in status of a claim which occurred 45 days or more before the claim log was provided. However, once all liability for a claim has been denied the log shall designate the claim as a denial, even if the claim was later accepted.

(d) The claim log of each former self-insured employer and each self-insured employer which changes or terminates the use of a third-party administrator shall be maintained by that self-insured employer as required by subsection (a).

(e) A claims administrator shall provide a copy of a claim log within 14 days of receiving a written request from the Administrative Director.

Note: Authority cited: Sections 59, 129.5, 133 and 5307.3, Labor Code. Reference: Sections 124, 129, 129.5, 138.4, 3702.8 and 5401, Labor Code.

HISTORY

1. New section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).
2. Amendment of subsection (b)(6) filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

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Subchapter 1.5. Injuries on or After January 1, 1990
Article 1. Audit, General Definitions

New query

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§10103.2. Claim Log--Contents and Maintenance

This section shall govern claim log maintenance on or after January 1, 2003.

(a) The claims administrator shall maintain annual claim logs listing all work-injury claims, open and closed. Each year's log shall be maintained for at least five years from the end of the year covered. Separate claim logs shall be maintained for each self-insured employer and each insurer for each adjusting location.

(b) Each entry in the claim log shall contain at least the following information:

(1) Name of injured worker.

(2) Claims administrator's claim number.

(3) Date of injury.

(4) An indication whether the claim is an indemnity or medical-only claim. Indemnity claims shall be differentiated from medical-only claims or any other claim where no indemnity payment(s) has been made. Claims that only require the provision of first aid, as defined by California Code of Regulations, title 8, section 9780(d), should not be included in the claim log.

(5) An entry if all liability for a claim has been denied at any time. All liability is considered to have been denied even if the administrator accepted liability for medical-legal expense.

(6) If the claim log is for a self-insured employer and a Certificate of Consent to Self-Insure has been issued, the name of the corporation employing the injured worker. If the claim log consists of claims for two or more members of an insurer group, the log shall identify the insurer for each claim.

(7) If the claim has been transferred from one adjusting location to another:

(A) The address of the new location shall be identified on the initial adjusting location's log along with the date of transfer.

(B) Claims that are transferred from one adjusting location to another shall be listed on the claim log of the new adjusting location for the year in which the claim was initially reported, not for the year in which the claim was transferred. The claim log shall also indicate the address of the old adjusting location along with the date of transfer.

(c) The entries on a log provided to the Administrative Director shall reflect current information, to show at least any changes in status of a claim which occurred 45 days or more before the claim log was provided. However, once all liability for a claim has been denied the log shall designate the claim as a denial, even if the claim was later accepted.

(d) The claim log of each former self-insured employer and each self-insured employer that changes or terminates the use of a third-party administrator shall be maintained by that self-insured employer as required by subsection (a).

(e) A claims administrator shall provide a copy of a claim log within 14 days of receiving a written request from the Administrative Director.

Note: Authority cited: Sections 59, 129.5, 133 and 5307.3, Labor Code. Reference: Sections 124, 129, 129.5, 138.4, 3702.8 and 5401, Labor Code.

HISTORY

1. New section filed 12-30-2002; operative 1-1-2003 pursuant to GovernmentCode section 11343.4 (Register 2003, No. 1).

2. Amendment of subsections (b)(4) and (b)(7), including redesignation and amendment of portions of subsection (b)(7) as new subsections (b)(7)(A)-(B), filed 4-20-2009; operative 5-20-2009 (Register 2009, No. 17).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 2. Claims Administration and Recordkeeping

New query

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§10104. Annual Report of Inventory.

(a) Each claims administrator shall maintain, and shall file with the Administrative Director, an Annual Report of Inventory for each of its adjusting locations. The report shall be filed annually by April 1. It shall include the name, address, and telephone number of the adjusting location and the name and title of the person responsible for audit coordination. Claims administrators shall report, as of the preceding January 1, the numbers of indemnity, denied, and medical-only claims reported to each of its adjusting locations during the preceding calendar year for insurers and private self- insured employers, or public self-insured employers. If the administrator adjusts for more than one entity at that location, the report shall give the total numbers of claims at that location and shall also identify the numbers of claims for each self-insured employer or insurer liable for the payment of compensation. Indemnity claims shall be differentiated on the Annual Report of Inventory from medical-only claims or any other claim where no indemnity payment(s) has been made.

(b) If a claims administrator relocates, opens a new adjusting location, closes an adjusting location, changes contact persons, changes the e-mail address, changes from third-party administered to self-administered or from self-administered to third-party administered, or changes from self-insured to insured, the claims administrator shall advise the Administrative Director by mailing written notice to the manager of the Audit Unit within 45 calendar days of the event.

(c) Adjusting locations that have no indemnity, denied, or medical-only claims reported during the preceding calendar year must file with the Administrative Director a statement indicating whether the location is actively adjusting workers' compensation claims. The statement, which shall be filed annually by April 1, shall contain the name, address, and telephone number of the adjusting location and the name and title of the person responsible for audit coordination.

(d)(1) A claims administrator's obligation to submit an Annual Report of Inventory under subdivision (a) of this section is waived upon a determination by the Administrative Director that the claims administrator is in compliance with the electronic data reporting requirements of the Workers' Compensation Information System, as set forth in California Code of Regulations, title 8, section 9702.

(2) Each claims administrator whose obligation to submit an Annual Report of Inventory is satisfied under subdivision (d)(1) of this section shall maintain and file with the Administrative Director an Annual Report of Adjusting Locations. This report shall be filed annually by April 1 of each calendar year and shall report, as of the preceding December 31, each of the claims administrator's adjusting locations. The report shall include the name, street and mailing address, physical zip code, e-mail address, fax number, and telephone number for each adjusting location and the name, title, e-mail address, fax number and telephone number of the person responsible for audit

coordination.

(3) The claims administrator shall notify the Administrative Director, by mailing written notice to the manager of the Audit Unit, of any change in the information provided in the Annual Report of Adjusting Locations. A reportable change shall include the relocation of the claims administrator or the opening or closing of an adjusting location. The notification shall be made within 45 calendar days after the effective date of the change.

(4) The waiver granted to a claims administrator under subdivision (d)(1) of this section shall be rescinded if the total number of claims reported by the claims administrator to the Audit Unit in a claim log submitted pursuant to California Code of Regulations, title 8, section 10107.1(a) is not within one percent of the total number of claims electronically reported by the claims administrator to the Workers' Compensation Information System for the same period of time as covered in the submitted claim log.

Note: Authority cited: Sections 59, 129.5, 133 and 5307.3, Labor Code. Reference: Sections 129, 129.5 and 138.6, Labor Code.

HISTORY

1. Renumbering of former section 10104 to section 10105 and new section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

2. Amendment filed 12-30-2002; operative 1-1-2003 pursuant to GovernmentCode section 11343.4 (Register 2003, No. 1).

3. Amendment filed 10-6-2003; operative 12-1-2003 (Register 2003, No. 41).

4. Amendment of section and Note filed 4-20-2009; operative 5-20-2009 (Register 2009, No. 17).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 3. Auditing

New query

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§10105. Auditing, Discretion of the Administrative Director.

To carry out the responsibility pursuant to Labor Code sections 129 or 129.5, the Administrative Director or his/her representative shall audit claims administrators' claim files and claim logs at such reasonable times as he/she deems necessary. The Administrative Director or his/her representative may also utilize the provisions of Government Code sections 11180 through 11191.

Note: Authority cited: Sections 59, 129, 129.5, 133 and 5307.3, Labor Code. Reference: Sections 129 and 129.5, Labor Code.

HISTORY

1. New article 3 heading, repealer of former section 10105 and renumbering and amendment of former section 10104 to section 10105 filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Codesection 11351 (Register 94, No. 4). For prior history, see Register 90, No. 4.

2. Amendment filed 12-30-2002; operative 1-1-2003 pursuant to GovernmentCode section 11343.4 (Register 2003, No. 1).

3. Amendment of section and Note filed 4-20-2009; operative 5-20-2009 (Register 2009, No. 17).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 3. Auditing

New query

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§10106. Random and Non-Random Audit Subject Selection; Complaint/Information Investigation.

(a) In its discretion, the Audit Unit may treat an affiliated group of insurers at a single adjusting location as individual insurers, or may combine all or any of them as a single insurer audit subject. In its discretion, the Audit Unit may treat parent and subsidiary self-insured employers at a single adjusting location as individual self-insureds, or may combine all or any of them as a single self-insured audit subject.

(b) The final selection of audit subjects shall be within the discretion of the Audit Unit. The Audit Unit may investigate information or complaints instead of, or in addition to, conducting an audit. Investigations and/or audits may be conducted if complaints or information indicate the possible existence of claims handling practices which would be assessed as a civil penalty under Labor Code Section 129.5(d).

(c) The Audit Unit shall select at least half of its audit subjects at random from any available listing of adjusting locations of workers' compensation insurers, self-insured employers, self-insured joint powers authorities, legally uninsured employers, and third-party administrators. If, after the results of an audit become final, none of the criteria qualifying an audit subject for a return non-random audit pursuant to subsection (f) of this section exist, the audit subject shall be removed from the pool of potential random audit subject selection for three years. However, eligibility under this subsection for removal from the pool for random audit subject selection shall not bar the non-random selection of the audit subject pursuant to this section or Labor Code Section 129(b).

(d) In order to establish priorities for audits pursuant to Labor Code s129(b), the Audit Unit shall review and compile complaints and information that indicate a claims administrator is failing to meet its obligations under Divisions 1 or 4 of the Labor Code or regulations of the administrative director.

(1) The information and complaints shall be tracked and compiled into a list of Claims Administrators Identified for Potential Non-Random Investigation as follows:

(i) Complaints or information available to the Audit Unit which indicate possible violations of the kind which, if found on audit, would be subject to the assessment of administrative penalties or issuance of notices of compensation due shall be retained in potential audit subject files by claims adjusting locations. Factual information and complaints shall be weighted on the basis of apparent severity of the alleged violation, using the assessment categories set forth in the subsections (a) through (d) of s10111 and s10111.1 to set a point value.

An alleged violation that would fall within subsection (a) is given one point, an alleged violation that would fall within subsection (b) is given five points, an alleged violation that would fall within subsection (c) is given ten

points, and an alleged violation that would fall within subsection (d) is given fifty points. When multiple violations are alleged in one complaint, each potential violation is given the appropriate point(s).

Points assigned for violations which are evidenced by decisions or findings rendered by the WCAB or Rehabilitation Unit shall be multiplied by ten.

(ii) Periodically, the audit unit shall review and analyze the complaint and information data in order to establish a list of Claims Administrators Identified for Potential Non-Random Investigation. The total number of points assigned to a claims administrator at an adjusting location shall be compared to the total number of claims reported at that claims adjusting location as indicated on the Annual Report of Inventory or the Self Insurer's Annual Report. The claims administrators shall be ranked on the list of Claims Administrators Identified for Potential Non-Random Investigation on the basis of the ratio of weighted complaints to case load size at each adjusting location. It is within the discretion of the Audit Unit to determine when new lists shall be established.

(2) The audit unit shall select any number of the highest ranking claims adjusting locations for investigation from the list of Claims Administrators Identified for Potential Non-Random Investigation.

(i) The Audit Unit shall notify the claims administrator that it will conduct an investigation, and shall specify the files it will review by providing the names of the injured workers. The Audit Unit shall give the claims administrator a minimum of three working days notice of the date of commencement of the investigation. Notice may be given by telephone. The claim files shall be made available to the Audit Unit at the time of the commencement of the investigation. The Audit Unit may examine claim files and require a claims administrator to provide documents and information.

(ii) The Audit Unit shall examine the selected files and shall assign points for each violation found in the files in accordance with the point system set forth in subsection (d)(1)(i), except that there shall be no multiplier for violations evidenced by decisions or findings of the WCAB or Rehabilitation Unit. Points shall be assigned for every violation found in the file, both violations that were alleged in the complaints and additional violations found by the audit unit.

(iii) The Audit Unit shall send a notice to the claims administrator which outlines the violations found in the files investigated. The claims administrator may request copies of the complaints relating to the files investigated. The complaints may be kept confidential by the audit unit if confidentiality is requested by the complainant.

(iv) The claims administrator may present documentation and/or argument to the Audit Unit to disprove any or all of the violations found by the audit unit in the investigated files. The documentation and argument must be post-marked or personally delivered to the Audit Unit within fourteen days of receipt of the letter outlining the violations.

(v) The Audit Unit shall consider documents and argument submitted by the claims administrator to disprove the violations found in the investigated files and determine whether there is a basis to alter any of the points previously assigned.

(vi) The adjusting locations shall then be ranked on a list of Claims Administrators Identified for Potential Non-

Random Audit on the basis of the ratio of violation points to the number of claims investigated at each adjusting location.

(e) The Audit Unit shall select non-random audit subjects from the list of Claims Administrators Identified for Potential Non-Random Audit, and shall endeavor to give priority in scheduling audits to those administrators that have been assigned the most points. However, the audit unit may also consider the results and recency of prior audits at the adjusting location, the resources of the audit unit, and the need to conduct random audits, in scheduling investigations and audits. The Audit Unit is not required to investigate or audit every claims administrator on the list, nor is it required to investigate or audit in the order in which claims administrators appear on the list.

If the Audit Unit is able to conduct more non-random audits than the number appearing on the list of Claims Administrators Identified for Potential Non-Random Audit, it may select any number of the next highest ranking adjusting locations appearing on the list of Claims Administrators Identified for Potential Non-Random Investigation. The adjusting locations shall then be investigated and ranked according to subsection (d)(2).

(f) Prior audit results shall be used independently as factual information to support selection of a claims administrator for non-random audit.

(1) The Audit Unit shall return for a repeat non-random audit of denied files of the audit subject within one to three years of the results of an audit becoming final if there is more than one unsupported denial and the number of unsupported denials exceeds 5% of the audited denied claims.

(2) The Audit Unit shall return for a repeat non-random audit of indemnity files of the audit subject within one to three years of the results of an audit becoming final if:

(i) The number of randomly selected audited files with violations involving the failure to pay indemnity exceeds 20% of the audited files in which indemnity is accrued and payable and the average amount of unpaid indemnity exceeds $200.00 per file in which indemnity is accrued and payable, or

(ii) The numbers of randomly selected files with violations involving the late first payments of temporary disability indemnity, permanent disability indemnity, vocational rehabilitation maintenance allowance, late subsequent indemnity payments, and late payments of death benefits, as mitigated for frequency under Section 10111.1(e)(3)(i) through (v), exceeds 30% of the audited files in which those indemnity payments have been made, and the number of audited files with violations involving the failure to issue benefit notices, as assessed under Section 10111.1(a)(7)(ii) of these regulations, exceeds 30% of the files in which there is a requirement to issue those notices.

(g) The Audit Unit shall send a claims administrator selected for non-random audit a Notice of Audit in accordance with s10107. The Notice of Audit for a non-random audit may be appealed as follows:

(i) Within 7 days after receiving a Notice of Audit the claims administrator may appeal its selection for audit by filing and serving a request for an appeals conference or a request for a written decision by the Administrative Director without a conference.

(ii) Within 21 days after the request for a written decision or an appeals conference is filed, the appellant shall file with the Administrative Director and serve a written statement setting forth the legal and factual basis of the appeal, and including documentation or other evidence which supports the appellant's position.

(iii) If a request for an appeals conference or a request for a written decision without conference or if the written statement and documentation are not timely filed and served under Subsections (g)(i) and (g)(ii), the claims administrator shall be deemed to have finally waived the issue of the propriety of its selection for audit. The claims administrator will be precluded from raising the issue at any subsequent appeals of Notices of Penalty Assessment or Notices of Compensation Due.

(iv) Service and filing are timely if the documents are placed in the United States mail, first class postage prepaid, or personally delivered between the hours of 8:00 a.m. and 5:00 p.m., within the periods specified in Subsections (g)(i) and (g)(ii). The original and all copies of any filing shall attach proof of service as provided in Section 10514.

(v) The appeal process shall be governed by Section 10115.2.

Note: Authority cited: Sections 59, 129.5, 133 and 5307.3, Labor Code. Reference: Sections 7, 53, 111, 124, 129 and 129.5, Labor Code; and Sections 11180, 11180.5, 11181 and 11182, Government Code.

HISTORY

1. Relocation of article 3 heading to article 5 and repealer and new section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4). For prior history, see Register 90, No. 4.

2. Amendment of subsection (b), (d)(2), and (e) filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section11351 (Register 96, No. 7).

3. Amendment of section and Note filed 10-26-98; operative 11-25-98 (Register 98, No. 44).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 1. Audit, General Definitions

New query

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§10106.1. Routine and Targeted Audit Subject Selection; Complaint Tracking; Appeal of Targeted Audit Selection

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For audits conducted on or after January 1, 2003:

(a) The Division of Workers' Compensation shall maintain and update annually a list of known adjusting locations of California workers' compensation claims. The list will be based on information provided to the Division in Annual Reports of Inventory submitted pursuant to California Code of Regulations, title 8, section 10104, data submitted to the Division's Workers' Compensation Information System pursuant to Labor Code section 138.6, and any other sources of information available. The list shall include all known adjusting locations, located in or out of California, of insurers, self-administered self-insured employers, and third-party administrators that administer California workers' compensation claims.

(b) The Audit Unit shall select each adjusting location from the list of adjusting locations for routine profile audit review pursuant to Labor Code section 129(b)(1) at least once every five years. Audit subjects may be selected in any order, and routine audits may be scheduled by the Audit Unit in a manner to best minimize travel expenses and utilize audit personnel efficiently.

(1) For routine audit subject selection pursuant to Labor Code section 129(b)(1), if the adjusting location includes claims of more than one insurance underwriting company, self-insured employer, or third-party administrator at the location and all claims at that location share the same local management, the location will be considered as one audit subject.

(2) Eligibility under this subsection for removal from the pool for routine audit subject selection shall not bar the targeted selection of the audit subject pursuant to subdivisions (c)(2), (c)(3), (c)(4) of this section, Labor Code section 129(b)(3), or for investigation and/or audit pursuant to California Code of Regulations, title 8, section 10106.5.

(c) Pursuant to Labor Code section 129(b), the Audit Unit may conduct a targeted profile audit review or full compliance audit of targeted audit subjects. An audit subject shall be selected for a targeted audit based on the following target audit criteria:

(1) Prior audit results pursuant to Labor Code section 129(b)(2) shall be used independently as factual information to support selection of a claims administrator for a return, targeted audit as follows:

(A) When a final audit report is issued, the report will include a final performance rating. The final performance rating will be calculated in the same manner as the performance audit review performance rating as set forth in California Code of Regulations, title 8, section 10107.1(c)(3), except that the rating shall be determined based on audit findings from all claim files randomly selected pursuant to section 10107(c)(1), (d)(1), and (e)(1), and selected additional claim files.

(B) If the audit subject's performance rating calculated pursuant to section 10107.1(c)(3) or (d)(3) fails to meet or exceed the worst 10% of performance ratings for all audits conducted in the three calendar years before the year preceding the year in which the current audit was commenced, the Audit Unit will return for a targeted audit of the audit subject within two years of the date the audit findings become final.

(C) In the final audit report, the Audit Unit shall notify the audit subject that a return, targeted audit will be conducted based upon its performance rating.

(D) Any appeal of the audit subject's selection for a targeted audit based upon the audit findings must be made in the same manner as an appeal of the Notice of Penalty Assessment as set forth in California Code of Regulations, title 8, section 10115.1, and must be made within seven days of receipt of the audit findings upon which the selection for targeted audit is based.

(2) Audit subjects may be selected for targeted audit based on final decisions or findings of the WCAB issued pursuant to Labor Code section 5814 as follows:

(A) The Division of Workers' Compensation will regularly submit to the Audit Unit copies of WCAB decisions, findings, and/or awards issued pursuant to Labor Code section 5814, and reports of WCAB cases involving section 5814 violations.

(B) The Audit Unit will establish a list of claims administrators identified for potential targeted audit based on the documentation provided pursuant to subdivision (c)(2)(A). For each adjusting location, the total number of decisions, findings, and/or awards issued pursuant to Labor Code section 5814 shall be compared to the total number of claims reported at that claims adjusting location for the last year for that potential audit subject, as indicated on the Annual Report of Inventory or the Self Insurer's Annual Report, or as indicated in the data reported by the claims administrator to the Division of Workers' Compensation as part of the Workers' Compensation Information System pursuant to Labor Code section 138.6. The Audit Unit may obtain data runs or claim logs from the claims administrator to verify the accuracy of the claims reported.

(C) The Audit Unit may select for target audit the highest-ranking subjects, based on the ratios of decisions, findings, and/or awards issued pursuant to Labor Code section 5814 compared to the number of claims reported at the adjusting location, from the list. The Audit Unit may consider the results and recency of prior audits at the adjusting location, the resources of the Audit Unit, and the need to conduct routine audits in scheduling targeted audits. The Audit Unit is not required to audit every claims administrator on the list, nor is it required to audit in the order in which claims administrators appear on the list.

(3) The Audit Unit may also target audit subjects based on credible complaints and/or information received by the Division of Workers' Compensation that indicate possible claims handling violations, except that the Audit Unit will not target audit subjects based only on anonymous complaints unless the complaint(s) is supported by credible

documentation. Complaints received by the Division of Workers' Compensation may be kept confidential if confidentiality is requested by the complaining party. In order to establish priorities for audits pursuant to this subsection, the Audit Unit shall review and compile complaints and information that indicate claims administrator adjusting locations are failing to meet their obligations under Divisions 1 or 4 of the Labor Code or regulations of the Administrative Director. The Audit Unit may contact a claims administrator and request information necessary to determine the validity of a complaint. Complaints and information alleging improper claims handling shall be tracked and compiled into a list of claims administrators identified for potential target audits in two manners:

(A) On the basis of overall gravity and frequency of potential violations as measured by assigned points:

1. Complaints or information indicating possible violations of the kind which, if found on audit, would be subject to the assessment of administrative penalties or issuance of notices of compensation due shall be weighted on the basis of apparent severity of the alleged violation. One point shall be assigned for each $100.00 in penalties assessable under the corresponding violations in California Code of Regulations, title 8, sections 10111 through 10111.2 of these regulations.

2. The Audit Unit may select for target audit the highest-ranking subjects, based on points assigned compared to the number of claims reported at the adjusting location. The Audit Unit may consider the results and recency of prior audits at the adjusting location, the resources of the Audit Unit, and the need to conduct routine audits in scheduling targeted audits. The Audit Unit is not required to audit every claims administrator on the list, nor is it required to audit in the order in which claims administrators appear on the list.

(B) On the basis of credible complaints or information indicating claims handling for which a civil penalty may be assessed pursuant to Labor Code section 129.5(e).

The Audit Unit may select for target audit the highest-ranking subjects based on the ratios of complaints or information regarding specific claims practices compared to the number of claims. In considering the potential for specific poor claims practices, the Audit Unit may consider the results and recency of prior audits at the adjusting location, the resources of the Audit Unit, and the need to conduct routine audits in scheduling targeted audits. The Audit Unit is not required to audit every claims administrator on the list, nor is it required to audit in the order in which claims administrators appear on the list.

(4) The Audit Unit may also select targeted audit subjects based on data from the Workers' Compensation Information System which indicates the claims administrator is failing to meet its obligations, including, but not limited to, high percentages of possible violations compared to other claims administrators. Possible violations include high percentages of apparent late first and/or subsequent indemnity payments, either overall or by class of indemnity, and/or high ratios of denied claims to indemnity claims.

(5) The Audit Unit may also target an audit subject for any of the following:

(A) Failure to produce a claim for the Audit Unit within 30 days of receipt of a written request in a profile audit review conducted pursuant to Labor Code section 129(b).

(B) Failure to pay or appeal pursuant to California Code of Regulations, title 8, section 10115.1 any Notice of Compensation Due issued by the Audit Unit.

(C) Failure to comply with the Workers' Compensation Information System (WCIS) requirements and timelines set forth in Labor Code section 138.6 or California Code of Regulations, title 8,, sections 9700 et seq.

(D) The assessment of or a stipulation to a civil penalty pursuant to Labor Code section 129.5(e).

(d) For targeted audits conducted in accordance with the target audit criteria set forth in subdivision (c) of this section:
(1) The Audit Unit shall send the audit subject selected for targeted audit a Notice of Audit in accordance with section 10107.1(a).

(2) For target audits, the Audit Unit may randomly select claims pursuant to section 10107.1 of these regulations and/or target claims on the basis that the Audit Unit has received information alleging the existence of an improper claim handling practice, and for the purpose of determining whether that practice occurred in those files. Companion claim files or additional claim files as defined by these regulations may be included for audit with the selected files.

(3) For all types of target audits and/or for targeted claims in any audit, the Audit Unit is not required to audit an entire claim file, but may audit only those parts of the claim file that pertain to the complaint or to a specific type of possible violation(s).

(4) The Notice of Audit for a targeted audit selected pursuant to subdivisions (c)(2) through (c)(5) of this section may be appealed as follows:

(A) Within 7 days after receiving a Notice of Audit the claims administrator may appeal its selection for audit by filing with the Administrative Director and serving on the Audit Unit a request for an appeals conference or a request for a written decision without a conference.

(B) Within 21 days after the request for a written decision or an appeals conference is filed, the appellant shall file with the Administrative Director and serve the Audit Unit with a written statement setting forth the legal and factual basis of the appeal, and including documentation or other evidence which supports the appellant's position.

(C) If a request for an appeals conference or a request for a written decision without conference or if the written statement and documentation are not timely filed and served under California Code of Regulations, title 8, section 10115.1(g)(1) and (g)(2), the claims administrator shall be deemed to have waived any issue concerning its selection for audit. The claims administrator will be precluded from raising the issue at any subsequent appeals of Notices of Penalty Assessment or Notices of Compensation Due.

(D) Service and filing are timely if the documents are placed in the United States mail, first class postage prepaid, or personally delivered between the hours of 8:00 a.m. and 5:00 p.m., within the periods specified in section 10115.1(g). The original and all copies of any filing shall attach proof of service as provided in California Code of Regulations, title 8, section 10975.

(E) The appeal process shall be governed by California Code of Regulations, title 8, section 10115.2.

Note: Authority cited: Sections 59, 129, 129.5, 133, 138.6, 138.7 and 5307.3, Labor Code. Reference: Sections 7, 53, 111, 124, 129, 129.5, 138.6 and 138.7, Labor Code; and Sections 11180, 11181 and 11182, Government Code.

HISTORY

1. New section filed 12-30-2002; operative 1-1-2003 pursuant to GovernmentCode section 11343.4 (Register 2003, No. 1).

2. Change without regulatory effect redesignating and amending formersubsections (c)(8)(i)-(v) to subsections (c)(8)(A)-(E) filed 5-1-2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 18).

3. Amendment of section and Note filed 4-20-2009; operative 5-20-2009 (Register 2009, No. 17).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 3. Auditing

New query

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§10106.5 Civil Penalty Investigation.

Notwithstanding California Code of Regulations, title 8, sections 10106.1 and 10107.1, if the Audit Unit has information indicating the possible existence of claims handling practices which would be assessable as a civil penalty under Labor Code section 129.5(e), it may conduct an investigation and/or audit pursuant to Labor Code sections 129 and 129.5. The Audit Unit may also utilize the provisions of Government Code sections 11180 through 11191 as the delagee of the Administrative Director's powers as a department head.
The Audit Unit shall report any suspected fraudulent activity uncovered during an audit and/or investigation to the appropriate law enforcement agencies, including but not limited to the Department of Insurance Fraud Bureau and the appropriate District Attorney having jurisdiction over the audit subject.

Note: Authority cited: Sections 129.5, 133 and 5307.3, Labor Code. Reference: Sections 11180 through 11191, Government Code; and Sections 59, 60, 111, 124, 129 and 129.5, Labor Code.

HISTORY

1. New section filed 10-26-98; operative 11-25-98 (Register 98, No. 44).

2. Amendment filed 12-30-2002; operative 1-1-2003 pursuant to GovernmentCode section 11343.4 (Register 2003, No. 1).

3. Amendment of first paragraph filed 4-20-2009; operative 5-20-2009 (Register 2009, No. 17).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 3. Auditing

New query

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§10107. Notice of Audit; Claim File Selection; Production of Claim Files; Auditing Procedure.

(a) Once a subject has been selected for an audit, the Audit Unit shall serve a Notice of Audit on the claims administrator. The Notice shall inform the administrator of its selection for audit, and shall include a request to provide the Audit Unit with a claim log or logs. The audit subject shall provide two copies of the specified claim log(s) within fourteen days of the date of the receipt of the Notice. The Audit Unit may select any or all claim files for audit.

(b) The Audit Unit shall send the audit subject a Notice of Audit Commencement identifying the files to be audited, except that no notice need be given to audit claim files which are the subject of inquiries or complaints. The audit shall commence no less than fourteen days from the date the Notice was sent, unless the audit subject agrees to earlier commencement.(c) The Audit Unit shall randomly select separate samples of indemnity, denied, and medical-only files from two years' of the audit subject's claim logs, except that if the earliest of the last two completed years has already been the subject of an audit, claims will be randomly selected from only the last completed year.

(1) The total number of indemnity files randomly selected for audit will be determined based on the following table:

Population	Sample Size
8 or less	all
9 - 15	1 less than total
9 - 15	1 less than total
16 - 19	2 less than total
20 - 23	3 less than total
24 - 27	4 less than total
28 - 30	5 less than total
31 - 33	6 less than total

34 - 36	7 less than total
37 - 38	8 less than total
39 - 41	9 less than total
42	32
43 - 44	33
45	34
46 - 47	35
48 - 49	36
50 - 51	37
52 - 53	38
54 - 55	39
56 - 57	40
58 - 59	41
60 - 61	42
62 - 63	43
64 - 65	44
66 - 67	45
68 - 70	46
71 - 72	47
73 - 74	48
75 - 77	49
78 - 79	50

80 - 82	51
83 - 84	52
85 - 87	53
88 - 89	54
90 - 92	55
93 - 95	56
96 - 98	57
99 - 101	58
102 - 104	59
105 - 107	60
108 - 110	61
111 - 114	62
115 - 117	63
118 - 120	64
121 - 124	65
125 - 128	66
129 - 131	67
132 - 135	68
136 - 139	69
140 - 143	70
144 - 148	71
149 - 152	72

153 - 156	73
157 - 161	74
162 - 166	75
167 - 171	76
172 - 176	77
177 - 181	78
182 - 187	79
188 - 192	80
193 - 198	81
199 - 204	82
205 - 210	83
211 - 217	84
218 - 223	85
224 - 230	86
231 - 238	87
239 - 245	88
246 - 253	89
254 - 261	90
262 - 270	91
271 - 279	92
280 - 288	93
289 - 298	94

299 - 308	95
309 - 319	96
320 - 330	97
331 - 342	98
343 - 354	99
355 - 367	100
368 - 381	101
382 - 396	102
397 - 411	103
412 - 427	104
428 - 444	105
445 - 463	106
464 - 482	107
483 - 503	108
504 - 525	109
526 - 549	110
550 - 575	111
576 - 603	112
604 - 633	113
634 - 665	114
666 - 700	115
701 - 739	116

740 - 781	117
782 - 827	118
828 - 879	119
880 - 936	120
937 - 1,000	121
1,001 - 1,072	122
1,073 - 1,154	123
1,155 - 1,248	124
1,249 - 1,356	125
1,357 - 1,483	126
1,484 - 1,633	127
1,634 - 1,814	128
1,815 - 2,036	129
2,037 - 2,315	130
2,316 - 2,677	131
2,678 - 3,163	132
3,164 - 3,852	133
3,853 - 4,904	134
4,905 - 6,710	135
6,711 - 10,530	136
10,531 - 23,993	137
23,994 +	138

(2) In conducting the audit, the Audit Unit shall calculate the frequency of files with violations as percentages of the files with exposure for violations after the following number of randomly selected indemnity files are audited:

Population	Sample Size
5 or less	all
11 - 13	2 less than total
14 - 16	3 less than total
17 - 18	4 less than total
19 - 20	5 less than total
21 - 23	6 less than total
24	17
25 - 26	18
27 - 29	19
30 - 31	20
32 - 33	21
34 - 36	22
37 - 39	23
40 - 41	24
42 - 44	25
45 - 48	26
49 - 51	27
52 - 55	28
56 - 58	29
59 - 62	30
63 - 67	31
68 - 72	32
73 - 77	33
78 - 82	34
83 - 88	35
89 - 95	36
96 - 102	37
103 - 110	38
111 - 119	39
120 - 128	40
129 - 139	41

140 - 151	42
152 - 164	43
165 - 179	44
180 - 197	45
198 - 217	46
218 - 241	47
242 - 269	48
270 - 304	49
305 - 346	50
347 - 399	51
400 - 468	52
469 - 562	53
563 - 696	54
697 - 905	55
906 - 1,272	56
1,273 - 2,091	57
2,092 - 5,530	58
5,531 +	59

If any of the following criteria are met after auditing the sample size as set forth in this subsection (c)(2), the Audit Unit will proceed to audit the remaining number of randomly selected indemnity files selected for audit pursuant to subsection (c)(1):

(i) The number of randomly selected audited files with violations involving the failure to pay indemnity exceeds 20% of those files in which indemnity is accrued and payable and the average amount of unpaid indemnity exceeds $200.00 per file in which indemnity is accrued and payable;

(ii) The numbers of randomly selected files with violations involving the late first payments of temporary disability indemnity, permanent disability indemnity, vocational rehabilitation maintenance allowance, late subsequent indemnity payments, and late payments of death benefits, as mitigated for frequency under Section 10111.1(e)(3)(i) through (v), exceeds 30% of the files in which those indemnity payments have been made;

(iii) The number of randomly selected audited files with violations involving the failure to issue benefit notices, as assessed under Section 10111.1(a)(7)(ii) of these regulations, exceeds 30% of those files in which there is a requirement to issue those notices.

The determination of whether or not to audit the number of files selected pursuant to subsection (c)(1) of this section shall not be the subject of appeal, and no preliminary report of findings will be issued to the audit subject before the determination is made.

(d) The total numbers of denied files and medical-only files randomly selected for audit will be determined based on the following table:

Population	Sample Size
7 - 10	1 less than total

11 - 14	2 less than total
15 - 17	3 less than total
18	14
19 - 20	15
21	16
22 - 23	17
24 - 25	18
26 - 27	19
28 - 29	20
30 - 31	21
32 - 33	22
34 - 36	23
37 - 38	24
39 - 41	25
42 - 43	26
44 - 46	27
47 - 49	28
50 - 52	29
53 - 55	30
56 - 59	31
60 - 63	32
64 - 67	33
68 - 71	34
72 - 75	35
76 - 80	36
81 - 85	37
86 - 90	38
91 - 96	39
97 - 102	40
103 - 109	41
110 - 116	42
117 - 124	43
125 - 132	44
133 - 141	45

142 - 151	46
152 - 163	47
164 - 175	48
176 - 189	49
190 - 205	50
206 - 222	51
223- 242	52
243 - 265	53
266 - 292	54
293 - 323	55
324 - 360	56
361 - 405	57
406 - 461	58
462 - 531	59
532 - 623	60
624 - 749	61
750 - 931	62
932 - 1,217	63
1,218 - 1,731	64
1,732 - 2,934	65
2,935 - 8,990	66
8,991 +	67

(e) In addition to randomly selected indemnity, denied, and medical-only files, the Audit Unit may also select for audit any or all files for which the Division of Workers' Compensation has received complaints within the past three years.

(f) The audit subject shall pay all expenses of an audit of an adjusting location outside the State of California, including per diem, travel expense, and compensated overtime of audit personnel.

(g) The audit subject shall make each of the files selected for audit available at the audit site at the time of audit commencement. If files are maintained in an electronic or other non-paper storage medium, the claims administrator shall, upon request, produce legible printed paper copies of the claim files, including all records of compensation payments.

(h) The Audit Unit shall have discretion to audit files in addition to those identified with the Notice of Audit Commencement. The audit subject shall make each of the additional files selected for audit available at the audit site within 14 days of receipt of written notice identifying the additional files.

(i) The audit subject shall provide the auditor(s) an adequate, safe, and healthful work space during the audit, which allows the auditors a reasonable degree of privacy. If this work space is not provided, the Audit Unit may require the audit subject to deliver the files to the nearest Audit Unit office for completion of the audit.

(j) The Audit Unit may obtain and retain copies of documentation or information from claim files to support the assessment of penalties.

(k) The audit subject shall have the opportunity to discuss preliminary findings and provide additional information at a post-audit conference.

(l) The Audit Unit may at any time request additional information or documentation in order to complete its audit. Such information may include documentation that, as specified by Labor Code Sections 3751(a) and 3752, compensation has not been reduced or affected by any insurance, contribution, or other benefit due to or received by or from the employee. The audit subject shall provide any requested documentation or other information within thirty days from the Audit Unit's request, unless the Audit Unit extends the time for good cause.

(m) The Audit Unit shall issue a report of audit findings which may include, but is not limited to, the following: one or more requests for additional documentation or compliance, Notices of Intention to Issue Notice of Compensation Due, Preliminary Notices of Penalty Assessments, Notices of Compensation Due, or Notices of Penalty Assessments. If any additional requested documentation is not provided within thirty days of receipt of the report, additional audit penalties may be assessed under Section 10111.1(d)(2) of these Regulations.

NOTE: Authority cited: Sections 59, 129.5, 133 and 5307.3, Labor Code. Reference: Sections 11180, 11180.5, and 11182, Goverment Code. Sections 111, 124, 129, 129.5, 3751 and 3752, Labor Code.

HISTORY

1. Repealer and new section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4). For prior history, see Register 90, No. 4.

2. New subsections (c)-(e), subsection relettering, amendment of newly designated subsection (g) and amendment of Note filed 10-26-98; operative 11-25-98 (Register 98, No. 44).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 1. Audit, General Definitions

New query

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§10107.1. Notice of Audit; Claim File Selection; Production of Claim Files; Auditing Procedure.

For audits conducted on or after January 1, 2003:

(a) Once a subject has been selected for an audit, the Audit Unit shall serve a Notice of Audit on the claims administrator. The Notice of Audit shall inform the claims administrator of its selection for audit, and may include a request to provide the Audit Unit with a claim log or logs. If the Audit Unit has requested claim logs, the audit subject shall provide two copies of each requested claim log within 14 days of the date of the receipt of the Notice of Audit. Only one copy of the requested claim log or logs shall be provided within 14 days of the date of the receipt of the Notice of Audit by the claims administrator if the copy is provided via electronic submission to the Audit Unit mailbox at DWCAuditUnit@dir.ca.gov.

(b) At least 14 days before the audit is scheduled, the Audit Unit shall send the audit subject a Notice of Audit Commencement identifying the claims to be audited. The audit shall commence no less than 14 days from the date the Notice of Audit Commencement was sent, unless the audit subject and Audit Unit agrees to earlier commencement. Claims selected for audit that are administered at the home of a telecommuting adjuster must be presented for audit at a California office location of the administrator, at a California location of the self insured employer, an Audit Unit office, or a Workers' Compensation Appeals Board district office. Other arrangements may be made as agreed between the audit subject and the Audit Unit.

(c) For profile audit reviews conducted pursuant to Labor Code section 129(b)(1), the Audit Unit shall randomly select samples of indemnity claims from the most recent three years of the audit subject's claim logs or from the list of claims for those years as reported to the Division of Workers' Compensation pursuant to Labor Code section 138.6 as part of the Workers' Compensation Information System. Claim samples randomly selected under this subdivision shall not include claims with a single indemnity payment that cannot be classified under the profile audit review performance standards set forth in subdivision (c)(3)(A) through (C)(3)(E). If any of the years have been the subject of a previous audit, claims will be randomly selected from the most recent unaudited year(s).

(1) The initial number of indemnity claims randomly selected for audit will be determined based on the following table:

Population	Sample Size
5 or less	all
6-10	1 less than total
11-13	2 less than total

14-16	3 less than total
17-18	4 less than total
19-20	5 less than total
21-23	6 less than total
24	17
25-26	18
27-29	19
30-31	20
32-33	21
34-36	22
37-39	23
40-41	24
42-44	25
45-48	26
49-51	27
52-55	28
56-58	29
59-62	30
63-67	31
68-72	32
73-77	33
78-82	34
83-88	35
89-95	36
96-102	37
103-110	38
111-119	39
120-128	40
129-139	41
140-151	42
152-164	43
165-179	44
180-197	45
198-217	46
218-241	47
242-269	48
270-304	49
305-346	50
347-399	51
400-468	52
469-562	53
563-696	54
697-905	55
906-1,272	56
1,273-2,091	57
2,092-5,530	58
5,531 +	59

(2) In addition to the randomly selected indemnity claims, the Audit Unit may audit any claims for which it has received a complaint or information over the past three years that indicate a failure to pay indemnity, including any companion claim needed to ascertain the extent to which benefits have been provided. Claims with complaints that are randomly selected will be audited as part of the random sample and included in the performance rating.

Complaints not involving a failure to pay indemnity will be provided to the audit subject, if confidentiality has not been requested, for review and corrective action, if warranted. Within 30 days of receipt of the report of audit findings issued pursuant to subdivision (f) of this section, the audit subject shall provide a written response to the Audit Unit, stating its review findings and corrective actions, if any.

(3) After reviewing the claims selected pursuant to subdivision (c)(1), the Audit Unit shall calculate the audit subject's profile audit review performance rating based on its review of the randomly selected claims. The profile audit review performance rating will be calculated as follows:

(A) The factor for the failure to pay accrued and undisputed indemnity shall be determined by:

1. Dividing the number of randomly selected claims with violations involving the failure to pay indemnity [pursuant to California Code of Regulations, title 8, section 10111.2, subdivisions (a)(1), (a)(2), (a)(3), (a)(4), and (a)(10)] by the number of randomly selected claims with accrued and payable indemnity, to produce a frequency rate.

2. Dividing the total amount of unpaid indemnity in randomly selected claims by the number of randomly selected claims with accrued and payable indemnity, to produce an average amount of unpaid indemnity per file with the obligation to pay indemnity.

3. Dividing the average amount of unpaid indemnity per randomly selected audited claim with the obligation to pay indemnity for the audit subject by the average amount of unpaid indemnity per randomly selected audited claim for all audit subjects for the three calendar years before the year preceding the year in which the current audit was commenced, to produce a severity rate.

4. Multiplying the frequency rate by the severity rate by a modifier of 2 to determine the factor for the failure to pay accrued and undisputed indemnity.

(B) The factor for the late first payment of temporary disability indemnity shall be determined by dividing the number of randomly selected claims with violations involving the late first payment of temporary disability indemnity [pursuant to section 10111.2, subdivisions (a)(5), (a)(8), and (a)(10)], or in claims that involve salary continuation, failure to comply with the requirements for first notices advising the injured employee of the provision of salary continuation in lieu of first temporary disability payments [pursuant to section 10111.2, subdivisions (b)(8)(B) and (b)(8)(C)], by the number of randomly selected claims in which temporary disability payments or first notices advising the injured employee of the provision of salary continuation in lieu of first temporary disability notices were required. In any claim that involves the payment of both salary continuation in lieu of first temporary disability payments and temporary disability payments, each benefit type paid will be considered in calculating this factor.

(C) The factor for the late first payment of permanent disability indemnity, vocational rehabilitation maintenance allowance, and death benefits [pursuant to section 10111.2, subdivisions (a)(6), (a)(7), (a)(8), and (a)(10)] shall be determined by dividing the numbers of randomly selected claims with violations involving late first payments of those benefits by the numbers of randomly selected claims with payments for those benefits. In calculation of this factor, claims shall be counted for each type of exposure and late first payment.

(D) The factor for late subsequent indemnity payments [pursuant to section 10111.2, subdivisions (a)(8), (a)(9), and (a)(10)] shall be determined by dividing the number of randomly selected claims with violations involving late indemnity payments subsequent to first payment by the number of randomly selected claims with subsequent indemnity payments.

(E) The factor for failure to comply with requirements for notices advising injured employees of the process for selecting Agreed Medical Examiners and/or Qualified Medical Examiners, and for injured workers with injuries prior to January 1, 2004, failure to comply with the requirements for notices advising injured workers of potential eligibility for vocational rehabilitation, or for injured workers with injuries on or after January 1, 2004, failure to comply with the requirements for notices advising injured workers of the right to the supplemental job displacement benefit, shall be determined by dividing the numbers of randomly selected claims with violations involving the failure to comply with the applicable requirement to issue the notices by the numbers of randomly selected claims with the requirement to issue the notices. In calculation of this factor, claims shall be counted for each type of exposure and violation.

(F) The audit subject's profile audit review performance rating will be determined by adding the factors calculated pursuant to subdivisions (c)(3)(A) through (c)(3)(E).

(4) If the audit subject's profile audit review performance rating meets or exceeds the worst 20% of performance ratings for all final audit reports issued for audits commenced the three calendar years before the year preceding the year in which the current audit was commenced, the Audit Unit will issue Notices of Compensation Due pursuant to California Code of Regulations, title 8, section 10110 but will assess no administrative penalties for violations found in the profile audit review.

(5) If the audit subject's profile audit review performance rating fails to meet or exceed the rating of the worst 20% of performance ratings as calculated based on all final audit findings as published in the Annual DWC Audit Reports over the three calendar years before the year preceding the year in which the current audit was commenced, the Audit Unit will conduct a full compliance audit by randomly selecting and auditing an additional sample of indemnity claims pursuant to subdivision (d). Written notification of the Audit Unit's findings from the profile audit review, the calculation of the profile audit review performance rating, and intent to proceed to a full compliance audit, will be provided to the audit subject in time for the timely filing of an objection. The audit subject may dispute whether or not a full compliance audit is merited under this subdivision at a post-profile audit review conference. Unless the audit subject demonstrates that the factual basis for the Audit Unit's calculation of the profile audit review performance rating is incorrect within two working days of the receipt of the rating or at the post profile audit review conference, the Audit Unit may complete the full compliance audit. The audit subject may appeal the issues pursuant to California Code of Regulations, title 8, section 10115.1 following the issuance of the final audit report. Failure of the audit subject to raise factual issues related to failing to meet or exceed the profile audit review performance standard within two working days of the receipt of the profile audit review performance rating or during the post-profile audit review conference shall constitute a waiver of appeal on those issues.

(d) If the audit subjects fails to meet or exceed the profile audit review performance standard, the Audit Unit shall conduct a full compliance audit by selecting and auditing an additional sample of indemnity claims.

(1) The total number of indemnity claims randomly selected for audit, including the number audited pursuant to subdivision (c)(1), will be determined based on the following table:

Population	Sample Size
8 or less	all
9-15	1 less than total
16-19	2 less than total
20-23	3 less than total
24-27	4 less than total
28-30	5 less than total
31-33	6 less than total
34-36	7 less than total
37-38	8 less than total
39-41	9 less than total
42	32
43-44	33
45	34
46-47	35
48-49	36
50-51	37
52-53	38
54-55	39
56-57	40
58-59	41
60-61	42
62-63	43
64-65	44
66-67	45
68-70	46
71-72	47
73-74	48
75-77	49
78-79	50
80-82	51
83-84	52
85-87	53
88-89	54
90-92	55
93-95	56
96-98	57
99-101	58
102-104	59
105-107	60
108-110	61
111-114	62
115-117	63
118-120	64
121-124	65
125-128	66
129-131	67
132-135	68
136-139	69
140-143	70
144-148	71
149-152	72
153-156	73
157-161	74

162-166	75
167-171	76
172-176	77
177-181	78
182-187	79
188-192	80
193-198	81
199-204	82
205-210	83
211-217	84
218-223	85
224-230	86
231-238	87
239-245	88
246-253	89
254-261	90
262-270	91
271-279	92
280-288	93
289-298	94
299-308	95
309-319	96
320-330	97
331-342	98
343-354	99
355-367	100
368-381	101
382-396	102
397-411	103
412-427	104
428-444	105
445-463	106
464-482	107
483-503	108
504-525	109
526-549	110
550-575	111
576-603	112
604-633	113
634-665	114
666-700	115
701-739	116
740-781	117
782-827	118
828-879	119
880-936	120
937-1,000	121
1,001-1,072	122
1,073-1,154	123
1,155-1,248	124
1,249-1,356	125
1,357-1,483	126
1,484-1,633	127
1,634-1,814	128

1,815-2,036 129
2,037-2,315 130
2,316-2,677 131
2,678-3,163 132
3,164-3,852 133
3,853-4,904 134
4,905-6,710 135
6,711-10,530 136
10,531-23,993 137
23,994 + 138

(2) In addition to the randomly selected indemnity claims, the Audit Unit may audit any claims for which it has received a complaint or information over the past three years that indicate a failure to pay indemnity or late-paid indemnity, including any companion claim needed to ascertain the extent to which benefits have been provided.

Complaints not involving a failure to pay indemnity or late paid indemnity will be provided to the audit subject, if confidentiality has not been requested, for self-review and corrective action, if warranted. Within 30 days of receipt of the report of audit findings issued pursuant to subdivision (f) of this section, the audit subject shall provide a written response to the Audit Unit stating its review findings and corrective actions, if any.

(3) After reviewing the claims selected pursuant to subdivision (d)(1), the Audit Unit shall calculate the audit subject's full compliance audit performance rating.

(A) The audit subject's full compliance audit performance rating will be calculated pursuant to subdivision (c)(3), except that it shall be based on the review of all claims selected pursuant to subdivision (d)(1).

(B) If the audit subject's full compliance audit performance rating meets or exceeds the worst 10% of performance ratings for all final audit reports issued for audits commenced in the three calendar years before the year preceding the year in which the current audit was commenced, the Audit Unit will issue Notices of Compensation Due pursuant to section 10110 and will assess administrative penalties only for violations involving unpaid and late paid compensation, pursuant to Labor Code section 129.5(c)(2).

(e) If the audit subject's full compliance audit performance rating fails to meet or exceed the rating of the worst 10% of performance ratings for all final audit reports issued for audits commenced in the three calendar years before the year preceding the year in which the current audit was commenced, the Audit Unit will audit all claims selected for audit for all violations, and also randomly select a sample of denied claims. Written notification of the Audit Unit's findings from the full compliance audit, the calculation of the full compliance audit performance rating, and intent to audit a sample of denied claims and assess penalties pursuant to Labor Code section 129.5(c)(3), will be provided to the audit subject in time for the timely filing of an objection. The audit subject may dispute whether or not it met or exceeded the full compliance audit performance standard at a meet and confer audit review conference. Unless the audit subject demonstrates that the factual basis for the Audit Unit's calculation of the full compliance audit performance rating is incorrect within two working days of the receipt of the rating or at the meet and confer audit review conference, the Audit Unit may complete the full compliance audit. The audit subject may appeal pursuant to section 10115.1 following the issuance of the final audit report. Failure of the audit subject to raise factual issues related to failing to meet or exceed the full compliance audit performance standard within two working days of the receipt of the full compliance audit performance rating or during the meet and confer audit review conference shall constitute a waiver of appeal on those issues.

(1) The number of denied claims randomly selected for audit will be based on the following table:

Population	Sample Size
6 or less	all
7-10	1 less than total
11-14	2 less than total
15-17	3 less than total
18	14
19-20	15
21	16
22-23	17
24-25	18
26-27	19
28-29	20
30-31	21
32-33	22
34-36	23
37-38	24
39-41	25
42-43	26
44-46	27
47-49	28
50-52	29
53-55	30
56-59	31
60-63	32
64-67	33
68-71	34
72-75	35
76-80	36
81-85	37
86-90	38
91-96	39
97-102	40
103-109	41
110-116	42
117-124	43
125-132	44
133-141	45
142-151	46
152-163	47
164-175	48
176-189	49
190-205	50
206-222	51
223-242	52
243-265	53
266-292	54
293-323	55
324-360	56
361-405	57
406-461	58
462-531	59

532-623 60
624-749 61
750-931 62
932-1,217 63
1,218-1,731 64
1,732-2,934 65
2,935-8,990 66
8,991 + 67

(2) In addition to the random samples of indemnity and denied claims, the Audit Unit may select for audit all claims for which the Division received complaints or information over the past three years that indicate the possible existence of any claims handling violations, including any companion claim(s) needed to ascertain the extent to which benefits have been provided.

(f) Following the conclusion of the audit, the Audit Unit shall issue a report of audit findings which may include, but is not limited to, the following: one or more requests for additional documentation or compliance, Notices of Intention to Issue Notice of Compensation Due, Preliminary Notices of Penalty Assessments, Notices of Compensation Due, or Notices of Penalty Assessments. If any additional requested documentation is not provided within thirty days of receipt of the report, additional audit penalties may be assessed under California Code of Regulations, title 8, section 10111.2(b)(23) of these Regulations.

(g) The audit subject shall pay all expenses of an audit of an adjusting location outside the State of California, including per diem, travel expense, and compensated overtime of audit personnel.

(h) The audit subject shall make each of the claim files selected for audit available at the audit site at the time of audit commencement. Claims will include but not be limited to the required contents of California Code of Regulations, title 8, section 10101.1. If claim files are maintained in an electronic or other non-paper storage medium, the claims administrator shall, upon request, provide to the Audit Unit, at the Audit Unit's discretion, direct computer access to electronic claim files and/or legible printed paper copies of the claim files, including all records of compensation payments. If a randomly selected indemnity, medical-only, or denied claim has been incorrectly classified as to type by the audit subject, the Audit Unit may randomly select an additional correctly designated claim file for audit, and may also assess penalties as appropriate in the misdesignated claim initially selected. If the audit subject fails to produce a claim selected for audit, the Audit Unit may assess a penalty for failure to produce the claim pursuant to section 10111.2(b)(3) and may also select for audit another claim of the same type to complete the random sample. If, after the issuance of the Notice of Audit Commencement that notified the audit subject that the claim was selected for audit, the audit subject has transferred a claim to a different adjusting location of the company being audited, the audit subject shall nonetheless produce the claim for audit within five working days of request, unless additional time is agreed upon by both the Audit Unit and the audit subject.

(i) The Audit Unit shall have discretion to audit claims in addition to those identified with the Notice of Audit Commencement. The audit subject shall make each of the additional claims selected for audit available at the audit site as follows:

(1) Open claims and closed claims stored on site within one working day of request;

(2) Closed claims stored off site within five working days of request, unless additional time is agreed upon by both the Audit Unit and the audit subject.

(j) The audit subject shall provide the auditor(s) an adequate, safe, and healthful workspace during the audit, which allows the auditors a reasonable degree of privacy. If the Audit Unit determines that this workspace is not provided,

the Audit Unit may require the audit subject to deliver the files to another California office location of the audit subject, an Audit Unit office, or a Workers' Compensation Appeals Board district office, for completion of the audit. Other arrangements may be made as agreed between the audit subject and the Audit Unit.

(k) The Audit Unit may obtain and retain copies of documentation or information from claim files to support the assessment of penalties.

(l) The audit subject shall have the opportunity to discuss preliminary findings and provide additional information at a post-audit conference.

(m) The Audit Unit may at any time request additional information or documentation related to the claims being audited in order to complete its audit. Such information may include documentation demonstrating that, as specified by Labor Code sections 3751 and 3752, compensation has not been reduced or affected by any insurance, contribution, or other benefit due to or received by or from the employee. The audit subject shall provide any requested documentation or other information within ten working days from the Audit Unit's request, unless the Audit Unit extends the time for good cause.

Note: Authority cited: Sections 59, 129, 129.5, 133 and 5307.3, Labor Code. Reference: Sections 11180, 11180.5, 11181 and 11182, Government Code; and Sections 111, 124, 129, 129.5, 139.5, 3751, 3752, 4658.5 and 4658.6, Labor Code.

HISTORY

1. New section filed 12-30-2002; operative 1-1-2003 pursuant to GovernmentCode section 11343.4 (Register 2003, No. 1).

2. Change without regulatory effect amending subsections (c)(3)(A)(i-a) and (c)(3)(A)(i-c) filed 5-1-2003 pursuant to section 100, title 1, CaliforniaCode of Regulations (Register 2003, No. 18).

3. Amendment of subsection (c)(3)(A)v. filed 10-6-2003; operative 12-1-2003 (Register 2003, No. 41).

4. Amendment of section and Note filed 4-20-2009; operative 5-20-2009 (Register 2009, No. 17).

8 CCR § 10107.1, 8 CA ADC § 10107.1
1CAC

8 CA ADC § 10107.1

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 3. Auditing

New query

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§10108. Audit Violations--General Rules.

The following general rules apply to audits and audit processes under Labor Code sections 129 and 129.5:

(a) If the date or deadline (including any applicable extension) to perform any act falls on a weekend or holiday, the act may be performed on the last business day before or the first business day after the weekend or holiday. A payment date which is changed under this provision shall not change the normal dates for later payments in an existing two-week payment schedule.
(b) For the purpose of imposing audit penalties, if the claims administrator does not record the date it received a document, it shall be deemed received five days after the latest date the sender wrote on the document.

(c) Audit penalties will be based on each claim's status when the claim is audited.

(1) If, at the time of the audit, the claims administrator has failed to perform a required act, but remedies the failure prior to the receipt of the Notice of Audit Commencement, when the claims administrator was notified that the claim was selected for audit, the claims administrator will be accountable for the violation. The penalty for an unlawful delay of more than 30 days in performing an act is the same as the penalty for not performing the act unless these regulations specifically provide otherwise. However the penalty will be mitigated for good faith because the act, though late, was eventually performed.

(2) If the claims administrator remedies a failure to perform a required act only after receipt of the Notice of Audit Commencement, the claims administrator will nonetheless be accountable for the violation as a failure to act and audit findings related to the violation will be based on the failure to perform the act. In cases where there is an unlawful delay of more than 30 days in performing an act and the act was performed only after the audit subject was notified that the claim was selected for audit, penalties will be assessed as though there was a failure to perform the act rather than late performance of the act. There will be no mitigation for good faith if the act was performed after notification to the audit subject that the claim was selected for audit.

(d) Penalties will not be assessed during the period a claims administrator is actively investigating its liability for provision of benefits or payment of compensation, provided that a Notice of Delay has been timely and properly issued in accordance with California Code of Regulations, title 8, sections 9812 or 9813. However, penalties shall still be issued for violations during the period of delay for: the failure to timely pay or object to medical bills for treatment authorized under Labor Code section 5402(c); the failure to timely pay or object to medical treatment bills in accordance with Labor Code section 4603.2, or the failure to timely pay or object to medical legal expenses in

accordance with Labor Code section 4620, et seq.

(e) Penalties will not be assessed for an act or omission where an injured worker's unreasonable refusal to cooperate in the investigation has prevented the claims administrator from determining its legal obligation to perform the act.

(f) Where a penalty is provided for failure to pay mileage fees related to medical treatment or evaluation, a penalty will be imposed if payment is not made at a rate that is at least the minimum rate adopted by the Director of the Department of Personnel Administration pursuant to Section 19820 of the Government Code for non-represented (excluded) employees at California Code of Regulations, title 2, section 599.631(a).

(g) Failure, delay, or refusal to pay compensation benefits or expenses shall be subject to the applicable penalties under California Code of Regulations, title 8, sections 10111, 10111.1, or 10111.2 unless the legal, factual, or medical basis for the failure, refusal, or delay is documented in the claim file.

(h) The Audit Unit will not assess penalties for violations of failure to make payment of indemnity due if the total indemnity is less than twenty-five dollars ($25.00) aggregate per claim. Although penalties may not be assessed, the audit subject shall pay all indemnity owed.

(i) Nothing in these regulations will bar the assessment of a civil penalty under Labor Code section 129.5(e), whether or not the audit subject meets or exceeds performance rating standards calculated pursuant to California Code of Regulations, title 8, section 10107.1(c)(3) or (d)(3).

(j) Claims that are randomly selected for audit pursuant to California Code of Regulations, title 8, sections 10107.1(c)(1) and (d)(1) will be considered as randomly selected claims for purposes of determining whether or not an audit subject meets or exceeds performance standards pursuant to sections 10107.1(c)(3) or (d)(3), whether or not complaints or information indicating claims handling violations in those claims have been received by the Audit Unit. If the Audit Unit cannot ascertain the extent to which benefits have been paid on a claim randomly selected for audit without auditing a companion or master claim to that claim, the Audit Unit may add the companion or master claim to the random sample. The companion or master claims will be considered as randomly selected claims for purposes of determining whether or not the audit subject meets or exceeds performance standards pursuant to sections 10107.1(c)(3) and/or (d)(3).

(k) Notwithstanding section 10111.2(a) and (b), penalties may be assessed for failure to timely submit an accurate Annual Report of Inventory regardless of whether or not an audit has been conducted, or, if an audit was conducted, whether or not the audit subject's performance rating in the key performance areas calculated pursuant to section 10107(c) warrants the audit of a full sample of indemnity claims pursuant to section 10107(c)(4), or a return, targeted audit based on performance in those areas pursuant to California Code of Regulations, title 8, section 10106(c)(2).

(l) Notwithstanding penalty amounts established pursuant to section 10111.2, penalties for late performance of an act may not exceed penalty amounts for the failure to perform an act.

(m) If more than one claims administrator has adjusted a claim file that is being audited or investigated, penalties will be assessed against the audit subject only for violations that occurred subsequent to the date the audit subject began adjusting the claim file, except that the audit subject will be assessed penalties for the failure to pay compensation due if the claim was open when transferred to the audit subject or re-opened subsequent to its transfer and the compensation remained unpaid. The audit subject is required to correct any failures to issue notices which are still pertinent, to recalculate and correct any improperly calculated payments due to the worker, and to pay any interest and increase due for late paid medical payments.

(n) Successor liability may be imposed on a claims administrator or insurer that has merged with, consolidated, or otherwise continued the business of a corporation or other business entity that is a responsible party and failed to meet its obligations under Divisions 1 and 4 of the Labor Code or regulations of the administrative director. The surviving claims administrator shall assume and be liable for all the liabilities, obligations and penalties of the prior corporation or business entity. Successor liability will be imposed if there has been a substantial continuity of business operations; and/or the new business uses the same or substantially the same work force. In such circumstances, due consideration

of the appropriateness of penalties with respect to the history of previous violations pursuant to Labor Code section 129.5(b)(3) will encompass findings related to the last audit of the predecessor claims administrator applied in conjunction with audit results of the successor claims administrator pursuant to California Code of Regulations, title 8, section 10111.2(c)(4).

Note: Authority cited: Sections 59, 129.5, 133, 138.3, 138.4, 138.6 and 5307.3, Labor Code. Reference: Sections 124, 129, 129.5, 138.6, 4600, 4603.2, 4621 and 5402, Labor Code; and Sections 7, 9, 10 and 11, Civil Code.

HISTORY

1. Renumbering of former section 10108 to section 10111 and new section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

2. Amendment of subsection (e) filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

3. Amendment of subsection (c) filed 10-26-98; operative 11-25-98 (Register 98, No. 44).

4. Amendment of subsections (c) and (f) and new subsections (h)-(n) filed 12-30-2002; operative 1-1-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 1).

5. Amendment of section and Note filed 4-20-2009; operative 5-20-2009 (Register 2009, No. 17).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 3. Auditing

New query

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§10109. Duty to Conduct Investigation; Duty of Good Faith.

(a) To comply with the time requirements of the Labor Code and the Administrative Director's regulations, a claims administrator must conduct a reasonable and timely investigation upon receiving notice or knowledge of an injury or claim for a workers' compensation benefit.

(b) A reasonable investigation must attempt to obtain the information needed to determine and timely provide each benefit, if any, which may be due the employee.

(1) The administrator may not restrict its investigation to preparing objections or defenses to a claim, but must fully and fairly gather the pertinent information, whether that information requires or excuses benefit payment. The investigation must supply the information needed to provide timely benefits and to document for audit the administrator's basis for its claims decisions. The claimant's burden of proof before the Appeal Board does not excuse the administrator's duty to investigate the claim.

(2) The claims administrator may not restrict its investigation to the specific benefit claimed if the nature of the claim suggests that other benefits might also be due.

(c) The duty to investigate requires further investigation if the claims administrator receives later information, not covered in an earlier investigation, which might affect benefits due.

(d) The claims administrator must document in its claim file the investigatory acts undertaken and the information obtained as a result of the investigation. This documentation shall be retained in the claim file and available for audit review.

(e) Insurers, self-insured employers and third-party administrators shall deal fairly and in good faith with all claimants, including lien claimants.

Note: Authority cited: Sections 59, 129.5, 133, 5307.3, Labor Code. Reference: Article 14, Section 4, California Constitution; Sections 124, 129, 133, 4061, 4550, 4600, 4636 through 4638, 4650, 4701 through 4703.5, 5402 and 5814, Labor Code;Ramirez v. WCAB, 10 Cal.App.3d 227, 88 CR 865, 35 CCC 383 (1970); and Section 790.03(h)(3), (5), (13), Insurance Code.

HISTORY

1. Relocation of article 4 heading to article 6, renumbering of former section

10109 to section 10113 and new section filed 1-28-94; operative 1-28-94.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 94, No. 4).

2. Amendment of subsection (d) filed 4-20-2009; operative 5-20-2009 (Register 2009, No. 17).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 4. Notices of Compensation Due

New query

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§10110. Notice of Intention to Issue a Notice of Compensation Due; Notice of Compensation Due; Review by Workers' Compensation Appeals Board.

(a) If as the result of an audit, the Administrative Director determines that compensation is due and unpaid to an employee, (s)he shall serve on the audit subject, personally or by first class mail, a Notice of Intention to Issue a Notice of Compensation Due specifying the amount, reason and period for which compensation is due. If liability for compensation is clear but the amount cannot be determined from information in the claim file, the Administrative Director may direct the claims administrator to gather the necessary additional information.

(b) The audit subject may file an Objection to the Notice of Intention within 14 days of receipt. The Objection shall state in detail the reasons the compensation found due is disputed and may include supporting documentation and legal argument.

(c) The Administrative Director will review any Objection, and may set the matter for an administrative meeting, which may be included as part of a post audit conference. The administrative meeting or the post audit conference may be set on the Administrative Director's own initiative or at the request of the audit subject. After review, the Administrative Director shall either dismiss the Notice of Intention to Issue a Notice of Compensation Due or issue a Notice of Compensation Due.

(d) If no timely Objection is submitted, the Administration Director may issue a Notice of Compensation Due. A Notice of Compensation Due which was issued without a timely Objection shall be final without right of further review unless the Workers' Compensation Appeals Board agrees to hear an appeal after a late Objection.

(e) A Notice of Compensation Due shall specify the amount, reason and period for which compensation is due and shall order payment of the compensation to the employee or dependent. The Notice of Compensation Due shall be served on the insurer, self-insured employer or third-party administrator personally or by certified or registered mail, and a copy shall be sent by first class mail to the affected employee or dependent. The compensation due must be paid within 15 days of receipt of the Notice of Compensation Due unless appealed to the Workers Compensation Appeals Board in accordance with Section 10115 of these Rules and the applicable rules of the Workers' Compensation Appeals Board.

NOTE: Authority cited: Sections 59, 129.5, 133, 4603.5, 5307.3, Labor Code. Reference: Sections 129, 139.5, 3207, 4453, 4550, 4600, 4621, 4636 through 4638, 4639, 4653, 4658, 4659, 4660, 4661.5, 4701-4703.5, 4900 and 4902, Labor Code; and Section 10952, Title 8, California Code of Regulations.

HISTORY

1. New article 4 heading, renumbering of former section 10110 to section 10114 and new section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 5. Administrative Penalties

New query

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§10111. Schedule of Administrative Penalties for injuries on or after January 1, 1990, but before January 1, 1994.

The administrative penalties set forth in subsections (a) through (d) of this section will be imposed for injuries occurring on or after January 1, 1990, but before January 1, 1994, subject to any applicable mitigation or exacerbation under subsection (e) of this section.

(a) A penalty of up to $100 for each violation shall be assessed when there is:

(1) Failure to make full payment of 10% self-imposed increase when temporary disability indemnity or permanent disability indemnity is overdue. The penalty for this violation is:

If the self-imposed increase was not paid or was only partially paid, the audit penalty is based on the amount of the underlying indemnity and is as follows:

$25 if the late-paid indemnity totals not more than 3 days;

$50 if the late-paid indemnity totals more than 3 but not more than 7 days;

$75 if the late-paid indemnity totals more than 7 but not more than 14 days;

$100 if the late paid indemnity totals more than 14 days.

(2) Failure to provide first permanent disability payment when due and/or within 14 days after temporary disability payments are terminated. The penalty for this violation is:

$25 if the first payment was made 1 to 2 days late;

$50 if the first payment was made 3 to 7 days late;

$75 if the first payment was made 8 to 14 days late;

$100 if the first payment was made more than 14 days late.

(3) Failure to respond to a written request for medical treatment of injured worker within 20 days of the date of request. The penalty for this violation is:

$25 for a response made from 1 to 7 days late;

$50 for a response made from 8 to 15 days late;

$75 for a response made from 16 to 34 days late;

$100 for failure to respond for more than 35 days.

(4) Failure to provide, upon request, any transportation costs when due to injured worker for medical care. The penalty for this violation is:

$25 for $10 or less in expense;

$50 for more than $10, to $20, in expense;

$75 for more than $20, to $40, in expense;

$100 for more than $40 in expense.

(5) Failure to document average weekly earnings if temporary disability indemnity is being paid at less than the maximum rate. The penalty for this violation is $100.

(6) Failure to make the first payment of temporary disability indemnity not later than 14 days after the date of the employer's knowledge of injury and disability pursuant to Labor Code Section 4650(a). The penalty for this violation is:

$25 if the first payment was made 1 to 2 days late;

$50 if the first payment was made 3 to 7 days late;

$75 if the first payment was made 8 to 14 days late, and/or if all indemnity then due was not paid but was paid with a subsequent payment;

$100 if the first payment was made more than 14 days late, and/or if all indemnity then due was not paid with the first payment and remains unpaid at the time of audit.

(7) Failure to follow the Rules and Regulations established by the Administrative Director for the purpose of carrying out the workers' compensation provisions in Labor Code Section 3200 through Section 6002. The penalty for this violation is:

[i] For each failure to include in a claim file a copy of the Employee's Claim for Worker's Compensation Benefits, DWC Form 1, showing the date the form was provided to and received from the employee, or documentation of the date the claim form was provided to the employee if the employee did not return the form, the penalty is:

$100 if there were any late indemnity payments, or if notice of acceptance of the claim was not issued within 90 days after the employer's date of knowledge of injury and disability, or if the claim was denied.

[ii] For each failure to issue a notice of benefits as required by Title 8, California Code of Regulations, Division 1, Chapter 4.5, Subchapter 1, Article 8, beginning with Section 9810, or by Title 8, California Code of Regulations, Division 1, Chapter 4.5, Subchapter 1.5, Article 7, beginning with Section 10122, unless penalties apply and are assessed under Section 10111(b)(2) of these regulations, the penalty is $100.

[iii] For each notice of benefits which was not issued timely as provided in Title 8, California Code of Regulations, Division 1, Chapter 4.5, Subchapter 1, Article 8, beginning with Section 9810, or as provided in Title 8, California Code of Regulations, Division 1, Chapter 4.5, Subchapter 1.5, Article 7, beginning with Section 10122, the penalty is:

$25 for each notice of first, resumed, changed or final payment of temporary disability indemnity, wage continuation, death benefits, permanent disability indemnity, or VRMA which was issued from 1 to 7 days late;

$50 for each notice of first, resumed, changed or final payment of temporary disability indemnity, wage continuation, death benefits, permanent disability indemnity, or VRMA which was issued more than 7 days late, and for each delay in decision notice or denial notice which was issued from 1 to 7 days late;

$75 for each delay in decision notice or denial notice which was issued more than 7 days late.

[iv] For each Notice of Benefits required by Title 8, California Code of Regulations, Division 1, Chapter 4.5, Subchapter 1, Article 8, beginning with Section 9810, or by Title 8, California Code of Regulations, Division 1, Chapter 4.5, Subchapter 1.5, Article 7, beginning with Section 10122, which was materially inaccurate or incomplete, except an inaccurate or incomplete denial notice, the penalty is $25. For a materially inaccurate or incomplete denial notice the penalty is $100.

[v] For each failure to include in a claim file, or document attempts to obtain, any of the required contents specified in Section 10101, the penalty is $100.

[vi] For each failure to comply with any regulation of the Administrative Director, not otherwise assessed in these Regulations, the penalty is $100.

(8) Failure to pay or object to all documented Medical-Legal expenses within 60 days of receipt of billing and any required reports as provided for in Labor Code 4622. The penalty for this violation is:

$50 for each bill which was paid more than 60 days from receipt with interest and a 10% increase;

$75 for each bill which was paid more than 60 days from receipt where either interest or a 10% increase was not included;

$100 for each bill which was paid more than 60 days from receipt where neither interest nor a 10% increase was paid;

$100 for each bill which was not paid where no timely objection was sent.

(9) Failure to pay or object to expenses for medical treatment within 60 days of receipt of the bill and any required reports. The penalty for this violation is:

$25 for each bill of $100 or less, excluding interest and penalty;

$50 for each bill of more than $100, but no more than $200, excluding interest and penalty;

$75 for each bill of more than $200, but no more than $300, excluding interest and penalty;

$100 for each bill of more than $300, excluding interest and penalty.

(10) Failure to pay within ten days any indemnity due, which is not specified in subsections (a)(1) through (a)(9). The penalty for this violation is:

$25 for late payment of 3 days of indemnity or less;

$50 for late payment of more than 3 but no more than 7 days of indemnity;

$75 for late payment of more than 7 days of indemnity, or failure to pay 3 days of indemnity or less;

$100 for failure to pay more than 3 days of indemnity.

(b) A penalty of up to $500 for each violation shall be assessed when there is:

(1) Failure to maintain and provide a written claim log as defined in Section 10100(g) to the audit unit commencing

July 1, 1990, and thereafter. The claim log shall contain all claims received, whether liability has been accepted, and distinguish between Indemnity and Medical-only claims. The penalty for this violation is:

$25 for each failure to list on a claim log one or more of the following: employee's name; claim number; date of injury;

$25 for each misdesignation of an indemnity file as a medical-only file on the claim log;

$100 for each failure to identify subsidiary self-insured employers on the log;

$100 for each failure to identify the underwriting insurance company of an insurance group;

$100 for each failure to designate a denied claim on the log;

$100 for each claim not listed on the log;

$250 for each failure to provide the claim log to the Audit Unit within 14 days of receipt of a written request if the claim log was provided more than 14 but no more than 30 days from receipt of the request;

$500 for each failure for more than 30 days from receipt of a written request, to provide the claim log to the Audit Unit.

(2) Failure to comply with Labor Code Sections 4636, 4637 and 4644. The penalty for this violation is:

[i] The penalty for each failure to assign a qualified rehabilitation representative immediately after 90 days of aggregate temporary disability indemnity is $100 if the assignment was made or the employee returned to his or her usual and customary occupation more than 10 but not more than 20 days after 90 days of aggregate total disability, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $500.

[ii] The penalty for each failure to issue notice of medical eligibility for vocational rehabilitation services (if not previously issued) within 10 days after knowledge of a physician's opinion that the employee is medically eligible, or for failure to issue notice within 10 days after 366 days of aggregate total temporary disability, is $100 if the notice was issued not more than 10 days late, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $500.

[iii] The penalty for each failure to notify an injured employee of the reasons he or she is not entitled to any, or to any further, vocational rehabilitation services, and the procedure for contesting the determination of non-eligibility, is $100 if notification was issued more than 10 but not more than 20 days after the determination, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $500.

(c) A penalty of up to $1,000 for each violation shall be assessed when there is:

(1) Failure to pay or appeal penalties provided for in the Notice of Compensation Due within 15 days of the date of receipt of the Notice. The penalty for this violation is:

$250 for each assessment paid more than 15 but not more than 30 days after receipt;

$500 for each assessment paid more than 30 but not more than 45 days after receipt;

$1,000 for each assessment not paid within 45 days after receipt.

(2) Failure to comply with or appeal any final order of the Workers' Compensation Appeals Board within 30 days of service. The penalty for this violation is:

$250 for full compliance in more than 30 but not more than 45 days from the date of service, or for any late payment or failure to pay interest due;

$500 for full compliance (other than a late interest payment) in more than 45 but not more than 60 days from the date of service;

$750 for full compliance (other than a late interest payment) in more than 60 but not more than 75 days from the date of service;

$1,000 if there was not full compliance (other than failure to pay interest) within 75 days of the date of service.

(d) A penalty of up to $5,000 for each violation shall be assessed when there is:

(1) Failure to produce, on a second request, a legible paper copy of a claim files within 5 days of written notice by the Administrative Director or his representatives. The penalty for this violation is:

$100 if the file was produced not more than 3 days late;

$250 if the file was produced more than 3 but not more than 14 days late;

$500 if the file was produced more than 14 but not more than 29 days late;

$1,000 if the file was produced more than 29 but not more than 40 days late;

$2500 if the file was produced more than 40 days late but not more than 90 days late.

$5000 if the was produced more than 90 days late or was not produced.

(2) Denial of liability for a claim without supporting documentation.

The total penalty shall be determined by applying the penalty assessment amount listed in [i] for gravity, subtracting the amount listed in [ii] for good faith if applicable, and increasing or decreasing the penalty as applicable for history and frequency as set forth in [iii] and [iv]:

[i] For a claim involving potential for medical treatment only the penalty is $3,500;

For a claim involving potential for medical treatment and either temporary or permanent disability the penalty is $4,000;

For a claim involving potential for medical treatment and both temporary and permanent disability the penalty is $4,500;

For a claim involving potential for medical treatment, temporary disability, permanent disability and vocational rehabilitation the penalty is $5,000;

For a claim involving potential for death benefits the penalty is $5,000.

[ii] The penalty will be reduced by $1,000 for good faith if there was a reasonable attempt to investigate the claim.

[iii] Reduction or increase of the penalty for history shall be based on the following:

An audit subject having no prior Audit Unit history will receive a $500 reduction;

An audit subject having a prior Audit Unit history of no more than one audited unsupported denial will receive a $500 reduction;

An audit subject having a prior Audit Unit history of more than one audited unsupported denial but no more than 5% of audited denials as unsupported will receive no reduction or increase for history;

An audit subject having a prior Audit Unit history of more than one audited unsupported denial and more than 5% of audited denials as unsupported will receive a $500 increase.

[iv] Reduction or increase of the penalty for frequency shall be based on the following:

An audit subject having no more than one audited unsupported denial will receive a $500 reduction;

An audit subject having more than one audited unsupported denial but no more than 5% of audited denials which are unsupported will receive no reduction or increase for frequency;

An audit subject having more than one audited unsupported denial and more than 5% of audited denials which are unsupported will receive an increase of $500.

[v] The total amount assessed for a denial shall be reduced by 50% if the claim was accepted after the denial without evidence that the acceptance was the result of litigation or of the claim's selection for audit.

(3) Except as provided in subsection (d)(1) of this section, failure to comply with or appeal any lawful written request or order of the Administrative Director regarding a claim filed within 30 days. The penalty for this violation is:

$500 if there was compliance in more than 30 but not more than 40 days from receipt or order;

$1,000 if there was compliance in more than 40 but not more than 60 days from receipt of the request or order;

$2,500 if there was compliance in more than 60 but not more than 90 days of receipt fo the request or order;

$5,000 for failure to comply within 90 days of receipt of the request or order.

(4) Failure by a claims administrator to provide a claim form within 24 hours upon request of an injured worker or his/her agent. The penalty for this violation is:

$500 if the claim form was provided in more than 1 but not more than 5 working days from receipt of the request, if benefits were being provided to the employee at the time of the request;

$1,000 if the claim form was not provided within 5 working days of receipt of the request, if benefits were being provided to the employee at the time of the request;

$3,000 if the claim form was provided in more than 1 but not more than 5 working days from receipt of the request, if benefits were not being provided to the employee at the time of the request;

$5,000 if the claim form was not provided within 5 working days of receipt of the request, if benefits were not being provided to the employee at the time of the request.

(e) The penalties otherwise applicable under subsections (a) through (d) of this section shall be modified, if warranted, for good faith, history, and frequency in the same manner as penalties are modified for acts or omissions occurring on or after January 1, 1994 by Section 10111.1(e) of this Article.

NOTE: Authority cited: Sections 59, 129.5, 133, 138.3, 138.4, 139.5, 4603.5, 4627 and 5307.3, Labor Code. Reference: Sections 124, 129, 129.5, 4061, 4453, 4454, 4550, 4600, 4603.2, 4621, 4622, 4625, 4636 through 4638, 4639, 4641, 4642, 4650, 4651, 4701 through 4703.5, 4706, 4706.5, 5401, 5401.6, 5402, 5800 and 5814, Labor Code; and Section 2629.1(e), (f), Unemployment Insurance Code.

HISTORY

1. New section filed 1-18-90; operative 1-18-90 (Register 90, No. 4). New section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Relocation and amendment of article heading, renumbering of former section 10111 to section 10114 subsections (g)-(h) and renumbering and amendment of former section 10108 to section 10111 filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

3. Editorial correction of subsection (a)(2) (Register 95, No. 32).

4. Amendment of subsections (a), (a)(6), (a)(7)[ii], (a)(7)[iv] and (b)(1) filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

5. Amendment of subsection (b)(1) filed 7-30-96; operative 7-30-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 31).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 5. Administrative Penalties

New query

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§10111.1. Schedule of Administrative Penalties for Injuries on or After January 1, 1994.

The administrative penalties set forth in subdivisions (a) through (d) of this section will be imposed for injuries occurring on or after January 1, 1994, subject to any applicable mitigation or exacerbation under subdivision (e) of this section. Penalties will not be assessed for violations occurring during the period January 1, 1994 through March 31, 1994 for acts or omissions for which there previously existed no audit penalties.

(a) The following Group A violations carry penalties of up to $100:

(1) The penalty for each failure to pay the 10% self-imposed increase with a late indemnity payment in accordance with Labor Code section 4650(d) is:

$25 if the self-imposed increase was paid after the late indemnity payment;

If the self-imposed increase was not paid or was only partially paid, the audit penalty is based on the amount of the underlying indemnity and is as follows:

$25 if the late-paid indemnity totals not more than 3 days;

$50 if the late-paid indemnity totals more than 3 but not more than 7 days;

$75 if the late-paid indemnity totals more than 7 but not more than 14 days;

$100 if the late paid indemnity totals more than 14 days.

(2) The penalty for each failure to make the first payment of permanent disability indemnity within 14 days after the last payment of temporary disability indemnity, or within 14 days of knowledge of the existence of permanent disability when there is no temporary disability, is:

$25 if the first payment was made 1 to 2 days late;

$50 if the first payment was made 3 to 7 days late;

$75 if the first payment was made 8 to 14 days late;

$100 if the first payment was made more than 14 days late;

(3) The penalty for each failure to object or pay to the injured worker, within 60 days of receiving a request, reimbursement for the reasonable expense incurred for self-procured medical treatment in accordance with Labor Code section 4600, is:

$25 for $100 or less in expense;

$50 for more than $100, to $200, in expense;

$75 for more than $200, to $400, in expense;

$100 for more than $400 in expense.

(4) The penalty for each failure to pay mileage fees and bridge tolls when notifying the employee of a medical evaluation scheduled by the claims administrator, in accordance with Labor Code sections 4600 through 4621; or to pay mileage fees and bridge tolls within 14 days of receiving notice of a medical evaluation scheduled by the administrative director or the appeals board; or to object or pay the injured worker for any other transportation, temporary disability, meal or lodging expense incurred to obtain medical treatment or evaluation, within 60 days of receiving a request, is:

$25 for $10 or less in expense;

$50 for more than $10, to $50, in expense;

$75 for more than $50, to $100, in expense;

$100 for more than $100 in expense.

(5) The penalty for each failure to document a factual basis for paying less than the maximum indemnity rate is $100.

(6) The penalty for each failure to make temporary disability, permanent disability, death benefits or VRMA payments according to the payment schedule defined by California Code of Regulations, title 8, section 10100.1(x)

of these regulations is:

$25 for each payment made 1 to 2 days late;

$50 for each payment made 3 to 7 days late;

$75 for each payment made 8 to 14 days late;

$100 for each payment made more than 14 days late.

(7) The penalty for each failure to comply with any regulation of the Administrative Director specified in this subdivision is:

[i] For each failure to include in a claim file a copy of the Employee's Claim for Worker's Compensation Benefits, DWC Form 1, showing the date the form was provided to and received from the employee, or documentation of the date the claim form was provided to the employee if the employee did not return the form, the penalty is:

$100 if there was any late indemnity payments, or if notice of acceptance of the claim was not issued within 90 days after the employer's date of knowledge of injury and disability, or if the claim was denied.

[ii] For each failure to issue a notice of benefits as required by California Code of Regulations, title 8, beginning with section 9810, or by California Code of Regulations, title 8, beginning with section 10122, unless penalties apply and are assessed under section 10111.1 subdivisions (b)(2), (b)(3), (b)(4), (b)(5), (b)(6), (b)(7) or (b)(8), the penalty is $100.

[iii] For each Notice of Benefits which was not issued timely as provided in California Code of Regulations, title 8, beginning with section 9810, or as provided in California Code of Regulations, title 8, beginning with section 10122, unless penalties apply and are assessed under section 10111.1 subdivisions (b)(2), (b)(3), (b)(4), (b)(5), (b)(6), (b)(7) or (b)(8), the penalty is:

$25 for each notice of first, resumed, changed or final payment of temporary disability indemnity, wage continuation, death benefits, permanent disability indemnity, or VRMA which was issued from 1 to 7 days late;

$50 for each notice of first, resumed, changed or final payment of temporary disability indemnity, wage continuation, death benefits, permanent disability indemnity, or VRMA which was issued more than 7 days late, and for each delay in decision notice which was issued from 1 to 7 days late;

$75 for each delay in decision notice which was issued more than 7 days late.

[iv] For each notice of benefits required by California Code of Regulations, title 8, beginning with section 9810,

(except a materially misleading denial notice assessed under section 10111.1(b)(9)), or by California Code of Regulations, title 8, beginning with section 10122, which is materially inaccurate or incomplete, the penalty is $25.

[v] For each failure to include in a claim file, or document attempts to obtain, any of the required contents specified in section 10101.1 subdivisions (b), (c), (d), (e), (f), (g), (h), (i), (j), the penalty is $100.

[vi] For each failure to comply with any regulation of the Administrative Director, not otherwise assessed in this subchapter, the penalty is $100.

(8) The penalty for each failure to pay or object to a billing for a medical-legal expense, in the manner required by section 9794, within 60 days of receiving the bill and all reports and documents required by the Administrative Director incident to the services, is:

$25 for each bill which was paid more than 60 days from receipt with interest and a 10% increase;

$50 for each bill which was paid more than 60 days from receipt where either interest or a 10% increase was not included;

$75 for each bill which was paid more than 60 days from receipt where neither interest nor a 10% increase was paid.

$100 for each bill which was not paid at the time the audit subject was notified the claim was selected for audit where no timely objection was sent.

(9) The penalty for each failure to pay or object to, in the manner required by Labor Code section 4603.2, a bill for medical treatment provided or authorized by the treating physician, is as follows when the bill remains unpaid at the time the audit subject is notified that the claim was selected for audit. For the purpose of this penalty the treating physician will be presumed chosen by the employee unless the claims administrator demonstrates otherwise:

$25 for each bill of $100 or less, excluding interest and penalty;

$50 for each bill of more than $100, but no more than $200 excluding interest and penalty;

$75 for each bill of more than $200, but no more than $300, excluding interest and penalty;

$100 for each bill of more than $300, excluding interest and penalty.

(10) The penalty for each failure to pay or object to, in the manner required by Labor Code section 4603.2, a bill for medical treatment provided or authorized by the treating physician, is as follows when the bill was paid before the audit subject was notified that the claim was selected for audit:

$25 for each bill which included an increase and interest with the late payment of any uncontested amount of the bill, in accordance with Labor Code Section 4603.2;

$50 for each bill which included either the increase or interest with the late payment of any uncontested amount of the bill, in accordance with Labor Code Section 4603.2;

$75 for any bill which included neither the increase nor interest with the late payment of any uncontested amount of the bill, in accordance with Labor Code Section 4603.2.

(11) The penalty for each failure to pay or object to a vocational rehabilitation bill within 60 days of receipt, as required by California Code of Regulations, title 8, sections 10132 and 10132.1, is:

$25 for each bill of $100 or less;

$50 for each bill of more than $100, but no more than $200;

$75 for each bill of more than $200, but no more than $300;

$100 for each bill of more than $300.

(12) The penalty for each failure to make a required first payment of temporary disability indemnity within 14 days after the employer's date of knowledge of injury and disability is:

$25 if the first payment was made 1 to 7 days late;

$50 if the first payment was made 8 to 14 days late;

$75 if the first payment was made 15 to 21 days late;

$100 if the first payment was made more than 21 days late.

(13) The penalty for each underpayment of an indemnity payment (including death benefits and VRMA), when the balance of the indemnity was paid late, is:

$25 for late payment of the equivalent of 3 days of indemnity or less;

$50 for late payment of the equivalent of more than 3 but no more than 7 days of indemnity;

$75 for late payment of the equivalent of more than 7 but no more than 14 days of indemnity;

$100 for the late payment of the equivalent of more than 14 days of indemnity.

(14) The penalty for each failure to make a first payment of VRMA or death benefit when due is:

$25 if the first payment was made 1 to 7 days late;

$50 if the first payment was made 8 to 14 days late;

$75 if the first payment was made 15 to 21 days late;

$100 if the first payment was made more than 21 days late.

(b) The following Group B violations carry penalties of up to $500:

(1) The penalty for each failure to maintain or provide to the Audit Unit a claim log which complies with these Regulations is:

$25 for each failure to list on a claim log one or more of the following: employee's name; claim number; date of injury;

$25 for each misdesignation of an indemnity file as a medical-only file on the claim log;

$100 for each failure to identify self-insured employers on the log as required by California Code of Regulations, title 8, section 10103.1(b)(6);

$100 for each failure to identify the underwriting insurance company of an insurance group;

$100 for each failure to designate a denied claim on the log;

$100 for each claim not listed on the log;

$250 for each failure to provide the claim log to the Audit Unit within 14 days of receipt of a written request if the claim log was provided more than 14 but no more than 30 days from receipt of the request;

$500 for each failure for more than 30 days from receipt of a written request, to provide the claim log to the Audit Unit.

(2) The penalty for each failure to provide information regarding the Americans with Disabilities Act, the Fair Employment and Housing Act, and workers' compensation vocational rehabilitation as required by Labor Code section 4636(a) immediately after 90 days of aggregate temporary disability indemnity is $100 if the information was provided or the employee returned to his or her usual and customary occupation more than 10 but not more than 20 days after 90 days of aggregate total disability, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $400 if the notice was issued more than 30 days late, and $500 if the notice was overdue more than 40 days and was not issued at the time the audit subject was notified that the claim was selected for audit.

(3) The penalty for each failure to issue notice of medical eligibility for vocational rehabilitation services (if not previously issued) within 10 days after knowledge of a physician's opinion that the employee is medically eligible, or for failure to issue notice within 10 days after 366 days of aggregate total temporary disability, is $100 if the notice was issued not more than 10 days late, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $400 if the notice was issued more than 30 days late, and $500 if the notice was overdue more than 40 days and was not issued at the time the audit subject was notified that the claim was selected for audit. Where the injured worker is represented by an attorney and documentation in the claim file indicates that the injured worker's attorney has received a copy of the physician's report indicating the employee is medically eligible for vocational rehabilitation, and if the knowledge is of a physician's opinion other than the injured worker's treating physician, a physician selected from a panel provided by the DWC Medical Unit, or an agreed medical examiner, the penalty shall be assessed at 20% of the amount otherwise assessed under this subdivision and shall not exceed $100.

(4) The penalty for each failure to provide the employee with a copy of the treating physician's final report together with notice of the procedure to contest the treating physician's determination, in accordance with Labor Code section 4636(d), immediately upon receipt of that report, is $100 for compliance more than 10 but not more than 20 days after receipt of the treating physician's final report, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $400 if the notice was issued more than 30 days late, and $500 if the notice was overdue more than 40 days and was not issued at the time the audit subject was notified that the claim was selected for audit.

(5) The penalty for each failure to notify an injured employee of the reasons he or she is not entitled to any, or to any further, vocational rehabilitation services, and the procedure for contesting the determination of non-eligibility, as required by California Code of Regulations, title 8, sections 9813(a)(3) and 10131, is $100 if notification was issued more than 10 but not more than 20 days after the determination, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $400 if the notice was issued more than 30 days late, and $500 if the notice was overdue more than 40 days and was not issued at the time the audit subject was notified that the claim was selected for audit.

(6) The penalty for each failure to notify an injured employee that his or her injury may have caused permanent disability and the procedures for evaluating the permanent disability, or of the employer's position that the injury has caused no permanent disability and the employee's remedies, in the manner provided by California Code of Regulations, title 8, beginning with section 9810; is $100 if the notice was issued up to 10 days late, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $400 if the notice was issued more than 30 days late, and $500 if the notice was overdue more than 40 days and was not issued at the time the audit subject was notified that the claim was selected for audit.

(7) The penalty for each failure to notify a claimant of the denial of all death benefits claimed by that person (except a denial limited to all or any of: burial expense, benefits which were due to the injured worker before his or her death, or medical-legal expense), in the manner provided by California Code of Regulations, title 8, beginning

with section 9810, is $100 if the notice was issued up to 10 days late, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $400 if the notice was issued more than 30 days late, and $500 if the notice was overdue more than 40 days and was not issued at the time the audit subject was notified that the claim was selected for audit.

(8) The penalty for each failure to send a notice denying liability for all workers' compensation benefits, in accordance with California Code of Regulations, title 8, beginning with section 9810, is $100 if the notice was issued up to 10 days late, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $400 if the notice was issued more than 30 days late, and $500 if the notice was overdue more than 40 days and was not issued at the time the audit subject was notified that the claim was selected for audit.

(9) The penalty for each notice denying liability for all workers' compensation benefits, which was materially misleading, is $500. The penalty for each materially incomplete denial notice is $100.

(10) The penalty for each failure to pay any uncontested penalty assessment in a Notice of Penalty Assessments within 15 days of receipt of the Notice of Penalty Assessments is:

$100 for each assessment paid more than 15 but not more than 30 days after receipt;

$300 for each assessment paid more than 30 but not more than 45 days after receipt;

$500 for each assessment not paid within 45 days after receipt.

(11) The penalty for each failure to comply with California Code of Regulations, title 8, section 10104 is:

$100 for each period of 1 to 14 days' delay in filing the Annual Report of Inventory, to a maximum penalty of $500 for each Annual Report of Inventory;

$500 for each Annual Report of Inventory that overstates or understates the number of claims by 10% or more.

(c) The following Group C violations carry penalties of up to $1,000:

(1) The penalty for each failure to pay compensation as ordered in a Notice of Compensation Due within 15 days of receipt, if no timely Request for Review of Notice of Compensation Due was filed, is:

$250 if the compensation was paid more than 15 but not more than 30 days from receipt of notice;

$500 if the compensation was paid more than 30 but not more than 45 days from receipt of notice;

$1,000 for failure to pay the compensation within 45 days of receipt of notice.

(2) The penalty for each termination, interruption or deferral of vocational rehabilitation services other than as provided by Labor Code sections 4637(b), 4644(b) is $1,000.

(3) The penalty for each failure to pay or denial of rehabilitation maintenance allowance, temporary disability indemnity, or salary continuation in lieu of temporary disability indemnity, without a factual, medical or legal basis for the failure or denial, is:

$100 for the equivalent of 3 days or less of unpaid indemnity;

$200 for the equivalent of more than 3 but not more than 7 days of unpaid indemnity;

$300 for the equivalent of more than 7 but not more than 14 days of unpaid indemnity;

$500 for the equivalent of more than 14 but not more than 21 days of unpaid indemnity;

$750 for the equivalent of more than 21 but not more than 28 days of unpaid indemnity;

$1,000 for the equivalent of more than 28 days of unpaid indemnity.

(4) The penalty for each failure to pay permanent disability indemnity based on a reasonable estimate of permanent disability, or denial of permanent disability indemnity, without a factual, medical or legal basis, is:

$200 for up to 6 weeks of unpaid indemnity;

$400 for more than 6 but not more than 15 weeks of unpaid indemnity;

$750 for more than 15 but not more than 30 weeks of unpaid indemnity;

$1,000 for more than 30 weeks of unpaid indemnity.

(5) The penalty for each failure to pay or denial of death benefits to any claimant without a factual, medical or legal basis for the failure or denial, is:

$100 for the equivalent of 3 days or less of unpaid indemnity under Labor Code section 4701(b), or for up to $300 of unpaid burial expenses;

$200 for the equivalent of more than 3 but not more than 7 days of unpaid indemnity under Labor Code section 4701(b), or for more than $300, up to $600, of unpaid burial expenses;

$300 for the equivalent of more than 7 but not more than 14 days of unpaid indemnity under Labor Code section 4701(b), or for more than $600, up to $900, of unpaid burial expenses;

$500 for the equivalent of more than 14 but not more than 21 days of unpaid indemnity under Labor Code section 4701(b), or for more than $900, up to $1,500, of unpaid burial expenses;

$750 for the equivalent of more than 21 but not more than 28 days of unpaid indemnity under Labor Code section 4701(b), or for more than $1,500, up to $2,250, of unpaid burial expenses;

$1,000 for the equivalent of more than 28 days of unpaid indemnity under Labor Code section 4701(b), or for more than $2,250 of unpaid burial expenses.

The penalty for each failure to pay or denial of payment to any claimant of compensation which was accrued and unpaid to the injured worker at the time of the worker's death is the same penalty which would apply for failure to pay or denial of payment of that compensation to the injured worker.

The penalty under this subdivision does not supersede the penalty under subdivision 10111.1(d)(1).

(6) The penalty for each failure to investigate a claim as provided by California Code of Regulations, title 8, section 10109 of these regulations is:

$250 if the failure to investigate involved a claim for medical treatment only, with no reasonable expectation of liability for indemnity payments;

$500 if the failure to investigate involved a claim or reasonable expectation of liability for temporary or permanent disability indemnity or vocational rehabilitation benefits;

$1,000 if the failure to investigate involved a claim or reasonable expectation of liability for death benefits, or a combination of two or more of the following classes of benefits temporary or permanent disability indemnity or vocational rehabilitation.

This penalty does not supersede a penalty for denial of claim without an investigation and documentation supporting a factual, medical, or legal basis for denial as set forth in section 10111.1(d)(1).

(d) The following Group D violations carry penalties of up to $5,000:

(1) The penalty for each denial of all liability for a claim without documentation supporting a factual, medical, or legal basis for the denial is specified in this subdivision.

In order to avoid a penalty, the denial must state a legal, factual or medical basis recognized by applicable law and documented by information in the claim file. An employee's purported waiver of benefits in a compensable case is not a ground to deny liability.

The gravity portion of the penalty is based on the class or classes of benefits potentially payable if benefits were provided. The total penalty shall be determined by the applying the penalty assessment amount listed in [i] for gravity, subtracting the amount listed in [ii] for good faith if applicable, and increasing or decreasing the penalty as applicable for history and frequency as set forth in [iii] and [iv]:

[i] For a claim involving potential for medical treatment only the penalty is $3,500;

For a claim involving potential for medical treatment and either temporary or permanent disability the penalty is $4,000;

For a claim involving potential for medical treatment and both temporary and permanent disability the penalty is $4,500;

For a claim involving potential for medical treatment, temporary disability, permanent disability and vocational rehabilitation the penalty is $5,000;

For a claim involving potential for death benefits the penalty is $5,000.

[ii] The penalty will be reduced by $1,000 for good faith if there was a reasonable attempt to investigate the claim.

[iii] Reduction or increase of the penalty for history shall be based on the following:

An audit subject having no prior Audit Unit history will receive a $500 reduction;

An audit subject having a prior Audit Unit history of no more than one audited unsupported denial will receive a $500 reduction;

An audit subject having a prior Audit Unit history of more than one audited unsupported denial but no more than 5% of audited denials as unsupported will receive no reduction or increase for history;

An audit subject having a prior Audit Unit history of more than one audited unsupported denial and more than 5% of audited denials as unsupported will receive a $500 increase.

[iv] Reduction of the penalty for frequency shall be based on the following:

An audit subject having no more than one audited unsupported denial will receive a $500 reduction;

An audit subject having more than one audited unsupported denial but no more than 5% of audited denials

which are unsupported will receive no reduction or increase for frequency;

An audit subject having more than one audited denial and more than 5% of audited denials which are unsupported will receive an increase of $500.

[v] The total amount assessed for a denial shall be reduced by 50% if the claim was accepted after the denial without evidence that the acceptance was the result of litigation or of the claim's selection for audit.

(2) The penalty for each failure to comply with, show good cause for non-compliance with, or contest, within 30 days of receipt, any written request or order of the Administrative Director or Audit Unit which is not specified in subdivisions (b)(1), (c)(1), or (d)(5) of this section is:

$500 if there was compliance in more than 30 but not more than 40 days from receipt of the request or order;

$1,000 if there was compliance in more than 40 but not more than 60 days from receipt of the request or order;

$2,500 if there was compliance in more than 60 but not more than 90 days of receipt of the request or order;

$5,000 for failure to comply within 90 days of receipt of the request or order.

(3) The penalty for each failure by a claims administrator to provide a claim form within one working day of receipt of a request from an injured worker or the worker's agent is:

$500 if the claim form was provided in more than 1 but not more than 5 working days from receipt of the request, if benefits were being provided to the employee at the time of the request;

$1,000 if the claim form was not provided within 5 working days of receipt of the request, if benefits were being provided to the employee at the time of the request;

$3,000 if the claim form was provided in more than 1 but not more than 5 working days from receipt of the request, if benefits were not being provided to the employee at the time of the request;

$5,000 if the claim form was not provided within 5 working days of receipt of the request, if benefits were not being provided to the employee at the time of the request.

(4) The penalty for each failure to comply in full with any final award or order of the Workers' Compensation Appeals Board or the Rehabilitation Unit within 20 days of service, allowing an additional five days for service by mail, is:

For any failure to pay all amounts payable as awarded or ordered, including interest, when partial nonpayment is due to a miscalculation or oversight and all other amounts have been paid, the penalty amount shall be determined based on the equivalent amount of unpaid indemnity as assessed under subdivision (c)(3) of this section.

For late payment of an award or order, the penalty is:

$500 for compliance in more than 20 but not more than 35 days from the date of service;

$1,000 for compliance (other than a late interest payment) in more than 35 but not more than 60 days from the date of service;

$2,500 for compliance (other than a late interest payment) in more than 60 but not more than 90 days from the date of service;

$5,000 if there was not compliance (other than failure to pay interest) within 90 days of the date of service.

Penalties will be assessed separately for both late payment and the failure to pay a portion of an award or order.

(5) The penalty for each failure to produce a legible paper copy of a claim file as required by California Code of Regulations, title 8, section 10107 or at the time specified by the Administrative Director is:

$100 if the file was produced not more than 3 days late;

$250 if the file was produced more than 3 but not more than 14 days late;

$500 if the file was produced more than 14 but not more than 29 days late;

$1,000 if the file was produced more than 29 days late but not more than 40 days late;

$2,500 if the file was produced more than 40 days late but not more than 90 days late;

$5000 if the was produced more than 90 days late or was not produced.

(6) The penalty for providing a backdated or otherwise altered or fraudulent document to the Audit Unit, or intentionally withholding a document from the Audit Unit, which would have the effect of avoiding liability for the payment of compensation or an audit penalty is:

$5,000 for each backdated, altered, or withheld document. The amount of the penalty is not subject to reduction based on frequency, history, or good faith as set forth in subdivision (e) of this section.

The claims administrator shall not be subjected to penalty under this subdivision if it demonstrates by clear and convincing evidence that the backdating, alteration, or withholding of the document was due solely to unintentional clerical error.

(e) The penalties otherwise applicable under subdivisions (a) through (d) of this section shall be modified by any applicable provision of this subdivision (e). However, the method of modifying penalties for unsupported denials is set forth in section 10111(d)(2) and section 10111.1(d)(1) and is not governed by this subdivision (e).

(1) Modification for the gravity of each violation is included within the penalty assessment amounts listed in subdivisions (a) through (d);

(2) Modification for the good faith of the audit subject shall be determined based on documentation of attempts to comply with requirements of the Labor Code and the Administrative Director's regulations, and may result in a reduction of 20% for each applicable violation.

(3) Modification for frequency shall be considered for each type of violation. Frequency shall be determined by comparing the number of audited files which were randomly selected pursuant to section 10107(c) and (d) of these regulations in which there is an assessment for a specific type of violation to the total number of those randomly selected audited files in which the possibility of that type of violation exists. The frequency of violations in the complaint files selected for audit pursuant to section 10107(e) shall not be used to determine penalty amounts for these categories, except the mitigation or exacerbation of penalty amounts based on frequency of violations in the randomly selected files shall be applied to the audited complaint files.

[i] If there are assessments for late first payments of temporary disability indemnity in 10% or less of the audited files in which payments of temporary disability indemnity are made, the penalty amounts of these assessments will be reduced by 20%. If there are assessments for late first payments of temporary disability indemnity in more than 30% of the audited files in which payments of temporary disability indemnity are made, the penalty amounts of these assessments will be increased by 20%,

[ii] If there are assessments for late first payments of permanent disability indemnity in 10% or less of the audited files in which payments of permanent disability indemnity are made, the penalty amounts of these assessments will be reduced by 20%. If there are assessments for late first payments of permanent disability indemnity in more than 30% of the audited files in which payments of permanent disability indemnity are made, the penalty amounts of these assessments will be increased by 20%.

[iii] If there are assessments for late first payments of vocational rehabilitation maintenance allowance in 10% or less of the audited files in which payments of maintenance allowance in 10% or less of the audited files in which payments of maintenance allowance are made, the penalty amounts of these assessments will be reduced by 20%. If there are assessments for late first payments of vocational rehabilitation maintenance allowance in more than 30% of the audited files in which payments of maintenance allowance are made, the penalty amounts of these assessments will be increased by 20%.

[iv] If there are assessments involving late subsequent payments, including any payment in which all indemnity then due is not paid with that payment but is paid with a subsequent payment as assessed under subdivision (a)(13) of this section, of temporary disability indemnity, permanent disability indemnity, or vocational rehabilitation maintenance allowance in 10% or less of the audited files in which these subsequent payments

were made, the penalty amounts of these assessments will be reduced by 20%. If the number of audited files with assessments for late subsequent payments of temporary disability indemnity, permanent disability indemnity, or vocational rehabilitation maintenance allowance exceeds 30% of the total number of audited files with subsequent payments of these benefits, the penalty amounts of these assessments will be increased by 20%.

[v] If there are assessments involving late payments of death benefits in 10% or less of the audited files in which these payments were made, the penalty amounts of these assessments will be reduced by 20%. If the number of audited files with assessments for late payments of death benefits exceeds 30% of the total number of audited files with payments of death benefits, the penalty amounts of these assessments will be increased by 20%.

[vi] If there are assessments involving failure to issue benefit notices (other than notices specifically mentioned elsewhere in this subdivision (3)) in 10% or less of the audited files in which these benefit notices are required, no penalties will be assessed for those violations. If the number of audited files with assessments for failure to issue these notices exceeds 10%, but does not exceed 20%, the penalty amounts of these assessments will be reduced by 20%. If the number of audited files with assessments for failure to issue these notices exceeds 30% of the total number of audited files in which these notices are required, the penalty amounts of these assessments will be increased by 20%.

[vii] If there are assessments involving late provision of benefit notices (other than notices specifically mentioned elsewhere in this subdivision (3)) in 10% or less of the audited files in which these benefit notices are required, no penalties will be assessed for those violations. If the number of audited files with assessments for late issuance of these notices exceeds 10%, but does not exceed 20%, the penalty amounts of these assessments will be reduced by 20%. If the number of audited files with assessments for late issuance of these notices exceeds 30% of the total number of audited files in which these notices were required and issued, the penalty amounts of these assessments will be increased by 20%.

[viii] If there are assessments involving the failure to pay or object to medical expenses within 60 days of receipt of the billing in 10% or less of the audited files with a requirement to pay or object to medical bills within 60 days of receipt of billing, the penalty amounts of these assessments will be reduced by 20%. if the number of audited files with assessments for failure to pay or object to medical expenses within 60 days of receipt of the billing exceeds 30% of the total number of audited files in which there was a requirement to pay or object to medical bills within 60 days of receipt of billing, the penalty amounts of these assessments will be increased by 20%.

[ix] If there are assessments involving the failure to pay or object to medical-legal expenses within 60 days of receipt of the billing in 10% or less of the audited files containing medical-legal expenses, the penalty amounts of these assessments will be reduced by 20%. If the number of audited files with assessments for failure to pay or object to medical-legal expenses within 60 days of receipt of the billing exceeds 30% of the total number of audited files in which there was a requirement to pay or object to medical-legal expenses within 60 days of receipt of billing, the penalty amounts of these assessments will be increased by 20%.

[x] If there are assessments involving the failure to pay or object to vocational rehabilitation expenses within 60 days of receipt of the billing in 10% or less of the audited files containing vocational rehabilitation expenses, the penalty amounts of these assessments will be reduced by 20%. If the number of audited files with assessments for failure to pay or object to vocational rehabilitation expenses within 60 days of receipt of the billing exceeds 30% of the total number of audited files in which there was a requirement to pay or object to vocational rehabilitation expenses within 60 days of receipt of billing, the penalty amounts of these assessments will be

increased by 20%.

[xi] For injuries before January 1, 1994, if there are assessments involving the failure to assign a qualified rehabilitation representative within 10 days after 90 days of aggregate total disability in 10% or less of the audited files with 90 or more days of aggregate total disability, the penalty amounts of these assessments will be reduced by 20%. If the number of audited files with assessments involving the failure to assign a qualified rehabilitation representative within 10 days after 90 days of aggregate total disability exceeds 30% of the total number of audited files in which there was a requirement to assign a qualified rehabilitation representative within 10 days after 90 days of aggregate total disability, the penalty amounts of these assessments will be increased by 20%.

[xii] For injuries on or after January 1, 1994, if there are assessments involving the failure to provide information to the employee required by Labor Code section 4636(a) within 10 days after 90 days of aggregate total disability in 10% or less of the audited files with 90 or more days of aggregate total disability, the penalty amounts of these assessments will be reduced by 20%. If the number of audited files with assessments involving the failure to provide the information specified in section 4636(a) within 10 days after 90 days of aggregate total disability exceeds 30% of the total number of audited files in which there was a requirement to provide the information specified in section 4636(a) within 10 days after 90 days of aggregate total disability, the penalty amounts of these assessments will be increased by 20%.

[xiii] If there are assessments involving the failure to notify an employee in a timely manner of potential eligibility for vocational rehabilitation in 10% or less of the audited files in which these notices are required, the penalty amounts of these assessments will be reduced by 20%. If the number of audited files with assessments involving the failure to notify an employee in a timely manner of potential eligibility for vocational rehabilitation exceeds 30% of the total number of audited files in which these notices are required, the penalty amounts of these assessments will be increased by 20%.

[xiv] If there are assessments involving the failure to notify an employee in a timely manner of non-eligibility for vocational rehabilitation in 10% or less of the audited files in which these notices are required, the penalty amounts of these assessments will be reduced 20%. If the number of audited files with assessments involving the failure to notify an employee in a timely manner of non-eligibility for vocational rehabilitation exceeds 30% of the total number of audited files in which these notices are required, the penalty amounts of these assessments will be increased by 20%.

[xv] If there are assessments involving the failure to notify an employee in a timely manner of the procedure for evaluating the employee's permanent disability, as required by California Code of Regulations, title 8, section 9812(f)(2), (f)(4), (g)(2), and (g)(3), in 10% or less of the audited files in which these notices are required, the penalty amounts of these assessments will be reduced by 20%. If the number of audited files with assessments for failure to issue these notices exceeds 30% of the total number of audited files in which these notices are required, the penalty amounts of these assessments will be increased by 20%.

[xvi] If there are assessments involving the failure to notify an employee or claimant in a timely manner of the denial of all liability for a claim, or of all liability for death benefits, in 10% or less of the audited files in which these notices are required, the penalty amounts of these assessments will be reduced by 20%. If the number of audited files with assessments for failure to issue these notices exceeds 30% of the total number of audited files in which these notices are required, the penalty amounts of these assessments will be increased by 20%.

[xvii] If there is an assessment for the failure to timely respond to a request to provide or authorize medical treatment in no more than one audited file, the penalty amount of that assessment will be reduced by 20%. If the number of audited files with assessments for the failure to timely respond to a request to provide or authorize medical treatment, the penalty amounts for these assessments will be increased by 20%.

[xviii] If there are assessments involving the failure to pay temporary disability indemnity, permanent disability indemnity, death benefits, vocational rehabilitation maintenance allowance, self-imposed increase for late indemnity payment, interest, or penalty in 5% or less of the audited files in which any of these forms of compensation are accrued and payable, the penalty amounts of these assessments will be reduced by 20%. If the number of audited files with assessments for the failure to pay any of these forms of compensation is more than 20% of the audited files in which any of these forms of compensation is accrued and payable, the penalty amounts of these assessments will be increased by 20%.

[xix] If there are assessments for failure to include items or properly designate entries on a claim log, and if no more than ten, or no more than 1%, of the entries on the log are affected, whichever is smaller, the penalty amounts of these assessments will be reduced by 20%. If more than fifty, or more than 5% of the entries on the log are affected, whichever is smaller, the penalty amounts of these assessments will be increased by 20%.

[xx] If there are other violations assessed which are not specified in [i] through [xix] above in 5% or less of the audited files, the penalty amounts of these assessments will be reduced by 20%. If the number of audited files with assessments exceeds 20% of the audited files, the penalty amounts of these assessments will be increased by 20%.

(4) Modification of the history of previous violations, if any, shall be based on prior audits of the audit subject at the current adjusting location. However, no modification for history shall apply if a valid comparison cannot be made between the current and prior audit(s). The penalty shall be modified for history as follows:

[i] There will be a reduction of 20% of any penalty for which there was no increase in the penalty amount based on frequency as described in subdivisions (e)(3)[i] through (3)[xx] above in the previous audit, and for which there was a reduction in the penalty amount based on frequency in the present audit at the audited adjusting location.

[ii] There will be an increase of 20% of any penalty for which there was an increase in the penalty amount based on frequency as described in subdivisions (3)[i] through (3)[xx] above in the previous audit, and for which there was no decrease in the penalty amount based on frequency of violations in the present audit at the audited adjusting location, provided that any increased penalty is limited to the maximum provided by statute and regulation for the violation.

(5) No administrative penalties shall be assessed if the only violations found in an audit are violations which do not involve the denial of a claim without supporting documentation, or failure to pay or late payment of compensation, and the violations are found in 20% or less of the indemnity files audited.

(6) Penalties may be mitigated outside the above mitigation guidelines in extraordinary circumstances, when strict application of the mitigation guidelines would be clearly inequitable.

Note: Authority cited: Sections 59, 129.5, 133, 138.3, 138.4, 139.5, 4603.5, 4627 and 5307.3, Labor Code. Reference: Sections 124, 129, 129.5, 4061, 4453, 4454, 4550, 4600, 4603.2, 4621, 4622, 4625, 4636 through 4638, 4639, 4641, 4642, 4650, 4651, 4701 through 4703.5, 4706, 4706.5, 5401, 5401.6, 5402, 5800 and 5814, Labor Code; and Section 2629.1(e), (f), Unemployment Insurance Code.

HISTORY

1. New section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

2. Editorial correction inserting omitted text in subsection (e)(3)[xviii] (Register 95, No. 32).

3. Amendment of subsections (a)(7)[ii]-(a)(7)[iv], (b)(1), (b)(9), (d)(1) and (e)(3)[xv] filed 2-14-96; operative 2-14-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 7).

4. Amendment filed 10-26-98; operative 11-25-98 (Register 98, No. 44).

5. Amendment filed 4-20-2009; operative 5-20-2009 (Register 2009, No. 17).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 1. Audit, General Definitions

New query

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§10111.2. Full Compliance Audit Penalty Schedules; Target Audit Penalty Schedule.

(a) For full compliance audits conducted on or after January 1, 2003, administrative penalties will be assessed pursuant to subdivision (a) for audit subjects that fail to meet or exceed the profile audit review performance standards calculated pursuant to California Code of Regulations, title 8, section 10107.1(c)(3) but meet or exceed the full compliance audit performance standards calculated pursuant to section 10107.1(d)(3). However, for violations in claims with dates of injury from January 1, 1990 through December 31, 1993, penalty amounts may not exceed the amounts that would be assessed pursuant to California Code of Regulations, title 8, section 10111, and for violations in claims with dates of injury from January 1, 1994 through December 31, 2002, penalty amounts may not exceed the amounts that would be assessed pursuant to Section 10111.1:

(1) The penalty for each failure to pay the 10% self-imposed increase due because of a late indemnity payment is:

If the self-imposed increase was not paid or was only partially paid, the audit penalty is based on the amount of the underlying indemnity and is as follows:

$50 if the late-paid indemnity totals not more than 3 days;

$100 if the late-paid indemnity totals more than 3 but not more than 7 days;

$150 if the late-paid indemnity totals more than 7 but not more than 14 days;

$200 if the late paid indemnity totals more than 14 but not more than 21 days;

$300 if the late paid indemnity totals more than 21 but not more than 28 days;
$500 if the late paid indemnity totals more than 28 days.

(2) The penalty for each failure to pay or denial of rehabilitation maintenance allowance, temporary disability indemnity, or salary continuation in lieu of temporary disability indemnity, without a factual, medical or legal basis for the failure or denial, is:

$200 for the equivalent of 3 days or less of unpaid indemnity;

$400 for the equivalent of more than 3 but not more than 7 days of unpaid indemnity;

$600 for the equivalent of more than 7 but not more than 14 days of unpaid indemnity;

$1,000 for the equivalent of more than 14 but not more than 21 days of unpaid indemnity;

$1,500 for the equivalent of more than 21 but not more than 28 days of unpaid indemnity;
$2,000 for the equivalent of more than 28 but not more than 35 days of unpaid indemnity;

$3,000 for the equivalent of more than 35 but not more than 42 days of unpaid indemnity;

$5,000 for the equivalent of more than 42 days of unpaid indemnity.

(3) The penalty for each failure to pay permanent disability indemnity based on a reasonable estimate of permanent disability, or denial of permanent disability indemnity, without a factual, medical or legal basis, is:

$400 for up to 6 weeks of unpaid indemnity;

$800 for more than 6 but not more than 15 weeks of unpaid indemnity;

$1,500 for more than 15 but not more than 30 weeks of unpaid indemnity;

$2,000 for more than 30 but not more than 50 weeks of unpaid indemnity;

$3,000 for more than 50 but not more than 95 weeks of unpaid indemnity;

$5,000 for more than 95 weeks of unpaid indemnity.

(4) The penalty for each failure to pay death benefits pursuant to Labor Code section 4701 to any claimant without a factual, medical or legal basis for the failure, is:

$200 for the equivalent of 3 days or less of unpaid indemnity or for no more than $300 of unpaid burial expenses;

$400 for the equivalent of more than 3 but not more than 7 days of unpaid indemnity or for more than $300, but not more than $600, of unpaid burial expenses;

$600 for the equivalent of more than 7 but not more than 14 days of unpaid indemnity or for more than $600, but no more than $900, of unpaid burial expenses;

$1,000 for the equivalent of more than 14 but not more than 21 days of unpaid indemnity or for more than $900, but no more than$1,500, of unpaid burial expenses;

$1,500 for the equivalent of more than 21 but not more than 28 days of unpaid indemnity or for more than $1,500, but no more than $2,000, of unpaid burial expenses;

$3,000 for the equivalent of more than 28 but not more than 42 days of unpaid indemnity or for more than $2,250 of unpaid burial expenses;

$5,000 for the equivalent of more than 42 days of unpaid indemnity.

The penalty for each failure to pay to any claimant compensation which was accrued and unpaid to the injured worker at the time of the worker's death is the same penalty which would apply for failure to pay that compensation to the injured worker.

(5) The penalty for each late first payment of temporary disability indemnity is:

$100 if the first payment was made 1 to 3 days late

$200 if the first payment was made 4 to 7 days late

$250 if the first payment was made 8 to 14 days late;

$300 if the first payment was made 15 to 21 days late;

$400 if the first payment was made 22 to 30 days late.

Penalty amounts for payments made over 30 days late are assessed pursuant to California Code of Regulations, title 8, section 10108(c) and subdivision (a)(2) of this section.

(6) The penalty for each late first payment of permanent disability is:

$100 if the first payment was made 1 to 3 days late;

$200 if the first payment was made 4 to 7 days late

$250 if the first payment was made 8 to 14 days late;

$300 if the first payment was made 15 to 21 days late;
$400 if the first payment was made 22 to 30 days late.

Penalty amounts for payments made over 30 days late are assessed pursuant to section 10108(c) and subdivision (a)(3) of this section.

For purposes of this subdivision, the first payment of permanent disability indemnity shall be considered late if not made within 14 days after the last payment of temporary disability indemnity, or within 14 days of knowledge of the existence of permanent disability, whichever last occurs.

(7) The penalty for each late first payment of VRMA or death benefit is:

$100 if the first payment was made 1 to 3 days late;

$200 if the first payment was made 4 to 7 days late

$250 if the first payment was made 8 to 14 days late;

$300 if the first payment was made 15 to 21 days late;

$400 if the first payment was made 22 to 30 days late.

Penalty amounts for payments made over 30 days late are assessed pursuant to section 10108(c) and subdivision (a)(2) of this section.

(8) The penalty for each underpayment of temporary disability, permanent disability, death benefits, or VRMA, when the balance of the indemnity was paid late, or late paid self-imposed increases, not paid together with the late indemnity payment is:

$100 for late payment of the equivalent of 3 days of indemnity or less, except it is $25 for late paid self-imposed increases;

$200 for late payment of the equivalent of more than 3 but no more than 7 days of indemnity, except it is $50 for late paid self-imposed increases;

$250 for late payment of the equivalent of more than 7 but no more than 14 days of indemnity, except it is $75 for late paid self-imposed increases;

$300 for late payment of the equivalent of more than 14 but no more than 21 days of indemnity, except it is $100 for late paid self-imposed increases;
$400 for the late payment of the equivalent of more than 21 days of indemnity, except it is $125 for late paid self-imposed increases.

Penalty amounts for underpayments made more than 30 days late are governed by section 10108(c).

(9) The penalty for each failure to make temporary disability, permanent disability, death benefits or VRMA payments according to the payment schedule defined by section 10100.2(jj) is:

$100 for each payment made 1 to 3 days late

$200 for each payment made 4 to 7 days late

$250 for each payment made 8 to 14 days late;

$300 for each payment made 15 to 21 days late;

$400 for each payment made 22 to 30 days late.

Penalty amounts for payments made more than 30 days late are governed by section 10108(c).

(10) Penalty amounts assessed pursuant to subdivisions (a)(1) through (a)(9) will be increased by 100%, but will not exceed $5000 except as provided by Labor Code section 129.5(c)(3), if the failure to pay or late payment was in violation of an award or order of the Workers' Compensation Appeals Board, the Rehabilitation Unit, or the Administrative Director. When the award or order is not specific to, but only stated as a lump sum, of any benefit pursuant to subdivisions (a)(1) through (a)(9) above, the increased penalty amount of 100% as specified above shall be determined based on the equivalent amount of unpaid indemnity as assessed under subdivision (a)(2), (a)(3), or (a)(4) of this section. Increased penalties under this subdivision will be separately assessed for late compliance and/or the failure to pay any portion of an award or order.

(11) Notwithstanding Labor Code section 129.5(c)(1) and whether or not the audit subject has met or exceeded performance standards calculated pursuant to California Code of Regulations, title 8, section 10107.1(c)(3), penalties will be assessed for failure to pay, or late or partial payment of, a Notice of Compensation Due issued as a result of an audit conducted pursuant to Labor Code section 129(b). Penalties will be assessed as follows:
A penalty in the same amount as the total of the penalties applicable under subdivisions (a)(1) through (a)(4) and (a)(10) will be assessed for any compensation paid more than 15 but not more than 30 days after receipt of the Notice of Compensation Due;

A penalty in the amount of 200% of the total of the penalties applicable under subdivisions (a)(1) through (a)(4) and (a)(10) will be assessed for any compensation paid more than 30 but not more than 60 days late;

A penalty in the amount of 300% of the total of the penalties applicable under subdivisions (a)(1) through (a)(4) and (a)(10) will be assessed for any compensation not paid within 60 days.

(12) Notwithstanding Labor Code section 129.5(c)(2) and whether or not the audit subject has met or exceeded performance standards calculated pursuant to section 10107.1(d)(3), additional penalties will be assessed for late payment or failure of the audit subject to pay any administrative penalties assessed pursuant to this section that are not timely appealed pursuant to California Code of Regulations, title 8, section 10115.1. Penalties will be assessed as follows:
An additional penalty of 50% of the amount of each late paid penalty will be assessed for each penalty paid more than

30 but not more than 60 days from receipt of the Notice of Penalty Assessments;

An additional penalty of 100% of the amount of each applicable penalty will be assessed for each penalty not paid within 60 days of receipt of the Notice of Penalty Assessments.

(b) For full compliance audits conducted on or after January 1, 2003, administrative penalties will be assessed pursuant to subdivision (a) and this subdivision (b) for audit subjects that fail to meet or exceed the full compliance audit performance standards calculated pursuant to section 10107.1(d)(3). However, for violations in claims with dates of injury from January 1, 1990 through December 31, 1993, penalty amounts may not exceed the amounts that would be assessed pursuant to section 10111, and for violations in claims with dates of injury from January 1, 1994 through December 31, 2002, penalty amounts may not exceed the amounts that would be assessed pursuant to section 10111.1:

(1) The penalty for each failure to investigate a claim as provided by California Code of Regulations, title 8, section 10109 is:

$500 if the failure to investigate involved a claim for medical treatment only, with no reasonable expectation of liability for indemnity payments, or if the failure to investigate involved the need for medical treatment or testing, but did not involve uncompensated lost time or permanent disability;

$1,000 if the failure to investigate involved a claim or reasonable expectation of liability for only one of the following classes of benefits: temporary disability; permanent disability indemnity; or, vocational rehabilitation;

$2,500 if the failure to investigate involved a claim or reasonable expectation of liability for any combination two of the following classes of benefits: temporary disability; permanent disability indemnity; or, vocational rehabilitation;

$5,000 if the failure to investigate involved a claim or reasonable expectation of liability for death benefits, or for all of the following classes of benefits: temporary disability; permanent disability indemnity; and, vocational rehabilitation.

(2) The penalty for each denial of all liability for a claim without documentation supporting a factual, medical, or legal basis for the denial is specified in this subdivision.

In order to avoid a penalty, the denial must state a legal, factual or medical basis recognized by applicable law and documented by information in the claim file. An employee's waiver of benefits in an otherwise clearly compensable case is not a ground to deny liability.

The penalty is $2,500 for a claim involving the potential for medical treatment only, with no potential for liability for indemnity payments;

The penalty is $4,000 for a claim involving the potential liability for medical treatment and for only one of the following classes of benefits: temporary disability; permanent disability indemnity; or, vocational rehabilitation;

The penalty is $4,500 for a claim involving the potential liability for medical treatment and for any combination of two of the following classes of benefits: temporary disability; permanent disability indemnity; or, vocational rehabilitation;

The penalty is $5,000 for a claim involving the potential liability for death benefits, or for all of the following classes of benefits: medical treatment, temporary disability; permanent disability indemnity; and, vocational rehabilitation.

The penalty will be reduced by 20% for good faith if there was a reasonable attempt to investigate the claim.

The total amount assessed for a denial shall be reduced by 50% if the claim was accepted after the denial without evidence that the acceptance was the result of litigation or of the claim's selection for audit.

(3) The penalty for each failure to produce a legible paper copy of a claim file as required by California Code of Regulations, title 8, section 10107.1(h) or at the time specified by the Administrative Director is:

$100 if the file was produced not more than 2 days late;

$250 if the file was produced more than 2 but not more than 4 days late;

$500 if the file was produced more than 4 but not more than 7 days late;
$1,000 if the file was produced more than 7 days late but not more than 15 days late;

$2,500 if the file was produced more than 15 days late but not more than 30 days late;

$5000 if the was produced more than 30 days late or was not produced.

(4) The penalty for providing a backdated or otherwise altered or fraudulent document to the Audit Unit, or intentionally withholding a document from the Audit Unit, which would have the effect of avoiding liability for the payment of compensation or an audit penalty is: $5,000 for each backdated, altered, or withheld document.

(5) The penalty for each failure to object to or pay reimbursement to an injured worker for the reasonable expense incurred for self-procured medical treatment, in accordance with the timeframes set forth for the payment of a medical bill in Labor Code section 4603.2(b)(1), is:

$100 for $100 or less in expense;
$200 for more than $100, to $500, in expense;

$300 for more than $500, to $1,000, in expense;

$500 for more than $1,000 in expense.

(6) The penalty for each failure to pay reasonable expenses of transportation, meals, and lodging incident to reporting to an examination, together with one day of temporary disability indemnity for each day of wages lost when submitting to the examination, when notifying the employee of a medical evaluation scheduled by the claims administrator in accordance with Labor Code sections 4600 through 4621; or to pay these expenses within 14 days of receiving notice of a medical evaluation scheduled by the Administrative Director or the appeals board; or to object or pay the injured worker for any reasonable transportation expenses incurred to obtain medical treatment or evaluation, within 60 days of receiving a request, is:

$100 for more than $10, to $100, in expense;

$200 for more than $100, to $300, in expense;
$300 for more than $300, to $500, in expense.

$500 for more than $500 in expense.

(7) The penalty for each failure to document a factual basis for paying less than the maximum indemnity rate is:

$50 if the total indemnity, paid and unpaid, totals not more than 3 days;

$100 if the total indemnity totals more than 3 but not more than 7 days;

$150 if the total indemnity totals more than 7 but not more than 14 days;

$200 if the total indemnity totals more than 14 but not more than 21 days;

$300 if the total indemnity totals more than 21 but not more than 28 days;

$500 if the total indemnity totals more than 28 days.

(8) The penalty for each failure to comply with any regulation of the Administrative Director specified in this subdivision is:

[A] For each failure to include in a claim file a copy of the Employee's Claim for Worker's Compensation Benefits, DWC Form 1, showing the date the form was provided to and received from the employee, or documentation of the date the claim form was provided to the employee if the employee did not return the form, the penalty is:

$100 if there was any late indemnity payments, or if notice of acceptance of the claim was not issued within 90 days after the employer's date of knowledge of injury and disability, or if the claim was denied.

[B] For each failure to issue a notice of benefits as required by California Code of Regulations, title 8, section 9810, or by California Code of Regulations, title 8, beginning with section 10122, unless penalties are assessed pursuant to subdivisions (b)(14) through (b)(20), the penalty is $100.

[C] For each Notice of Benefits that was not issued timely as provided in California Code of Regulations, title 8, beginning with section 9810, or as provided in California Code of Regulations, title 8, beginning with section 10122, unless penalties are assessed pursuant to subdivisions (b)(14) through (b)(20), the penalty is:

$25 for each notice of first, resumed, changed or final payment of temporary disability indemnity, wage continuation, death benefits, permanent disability indemnity, or VRMA that was issued from 1 to 7 days late;

$50 for each notice of first, resumed, changed or final payment of temporary disability indemnity, wage continuation, death benefits, permanent disability indemnity, or VRMA that was issued more than 7 days late, and for each delay in decision notice which was issued from 1 to 7 days late;

$75 for each delay in decision notice that was issued more than 7 days late.

[D] For each notice of benefits required by California Code of Regulations, title 8, beginning with section 9810, [except a materially misleading or materially incomplete denial notice assessed under subdivision (b)(21)] or by California Code of Regulations, title 8, beginning with section 10117, or by California Code of Regulations, title 8, beginning with section 10122, or by California Code of Regulations, title 8, beginning with section 10133.50, [unless penalties are assessed pursuant to subdivision (b)(27)] that is materially inaccurate or incomplete, the penalty is $25.
[E] For each failure to include in a claim file, or document attempts to obtain, any of the required contents specified in section 10101.1(b), (c), (d), (e), (f), (g), (h), (i), (j) of these Regulations, the penalty is $100.

[F] For each failure to comply with any regulation of the Administrative Director, not otherwise assessed in this Subchapter, the penalty is $100.

(9) The penalty for each failure to pay or object to a billing for a medical-legal expense in the manner required by Labor Code section 4622, is:

$100 for each bill that was paid late with interest and increase;

$200 for each bill that was paid late where either interest or increase was not included;

$300 for each bill that was paid late where neither interest nor increase was paid.

$500 for each bill that was not paid at the time the audit subject was notified the claim was selected for audit where no timely objection was sent.
(10) The penalty for each failure to pay or object, in the manner required by law or regulation, to a bill for medical treatment provided or authorized by the treating physician, including medical treatment provided pursuant to Labor Code section 5402(c), is as follows when the bill remains unpaid at the time the audit subject is notified that the claim

was selected for audit:

$100 for each bill of $100 or less, excluding interest and penalty;

$200 for each bill of more than $100, but no more than $500 excluding interest and penalty;

$300 for each bill of more than $500, but no more than $1,000, excluding interest and penalty;

$500 for each bill of more than $1,000, excluding interest and penalty.

Any penalty assessed under this subdivision shall be doubled if the medical treatment provided by the physician was authorized by a reviewer, as defined by California Code of Regulations, title 8, section 9792.6(q), through a utilization review process established pursuant to Labor Code section 4610 and California Code of Regulations, title 8, section 9792.7.

(11) The penalty for each failure to pay or object, in the manner required by law or regulation, to a bill for medical treatment provided or authorized by the treating physician, including medical treatment provided pursuant to Labor Code section 5402(c), is as follows when the bill was paid before the audit subject was notified that the claim was selected for audit:

$100 for each bill that included an increase and interest with the late payment of any uncontested amount of the bill, in accordance with Labor Code section 4603.2;

$200 for each bill that included either an increase or interest with the late payment of any uncontested amount of the bill, in accordance with Labor Code section 4603.2;

$300 for each bill that included neither an increase nor interest with the late payment of any uncontested amount of the bill, in accordance with Labor Code section 4603.2.

Any penalty assessed under this subdivision will be no greater than the penalty that would have issued under subdivision (b)(10) of this section had the bill been unpaid at the time the audit subject was notified that the claim was selected for audit.

(12) The penalty for each failure to pay or object to a vocational rehabilitation bill within 60 days of receipt, as required by California Code of Regulations, title 8, sections 10132 and 10132.1, is:

$25 for each bill of $100 or less;

$50 for each bill of more than $100, but no more than $200;

$75 for each bill of more than $200, but no more than $300;

$100 for each bill of more than $300.

(13) The penalty for each failure to maintain or provide to the Audit Unit a claim log that complies with these Regulations is:

$25 for each failure to list on a claim log one or more of the following: employee's name; claim number; date of injury;
$50 for each misdesignation of an indemnity claim as a medical-only claim on the claim log;

$50 for each failure to distinguish on the claim log an indemnity claim that has no payment of indemnity from one that has indemnity payment(s).

$100 for each failure to identify self-insured employers on the log as required by section 10103.1(b)(6) of these Regulations;

$100 for each failure to identify the underwriting insurance company of an insurance group;

$100 for each failure to designate a denied claim on the log;

$100 for each claim not listed on the log;

$250 for each failure to provide the claim log to the Audit Unit within 14 days of receipt of a written request if the claim log was provided more than 14 but no more than 30 days from receipt of the request;

$500 for each failure for more than 30 days from receipt of a written request, to provide the claim log to the Audit Unit.

(14) The penalty for each failure to provide information regarding the Americans with Disabilities Act, the Fair Employment and Housing Act, and workers' compensation vocational rehabilitation as required by Labor Code section 4636(a) immediately after 90 days of aggregate temporary disability indemnity is $100 if the information was provided or the employee returned to his or her usual and customary occupation more than 10 but not more than 20 days after 90 days of aggregate total disability, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $400 if the notice was issued more than 30 days late, and $500 if the notice was overdue more than 40 days and was not issued at the time the audit subject was notified that the claim was selected for audit.

(15) The penalty for each failure to issue notice of medical eligibility for vocational rehabilitation services (if not previously issued) within 10 days after knowledge of a physician's opinion that the employee is medically eligible, or for failure to issue notice within 10 days after 366 days of aggregate total temporary disability, is $100 if the notice was issued not more than 10 days late, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $400 if the notice was issued more than 30 days late, and $500 if the notice was overdue more than 40 days and was not issued at the time the audit subject was notified that the claim was selected for audit. Where the injured worker is represented by an attorney and documentation in the claim file indicates that the injured worker's attorney has received a copy of the physician's report indicating the employee is medically eligible for vocational rehabilitation, and if the knowledge is of a physician's opinion other than the injured worker's treating physician, a physician selected from a panel provided by the DWC Medical Unit, or an agreed medical examiner, the penalty shall be assessed at 20% of the amount otherwise assessed under this subdivision and shall not exceed $100.

(16) The penalty for each failure to provide the employee with a copy of the treating physician's final report together with notice of the procedure to contest the treating physician's determination, in accordance with Labor Code section 4636(d), immediately upon receipt of that report, is $100 for compliance more than 10 but not more than 20 days after receipt of the treating physician's final report, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $400 if the notice was issued more than 30 days late, and $500 if the notice was overdue more than 40 days and was not issued at the time the audit subject was notified that the claim was selected for audit. However, if a separate penalty is assessed under subdivision (b)(17) for the violation, no penalty will be assessed under this subdivision. If the injured worker was notified of the procedure to contest the treating physician's determination, but no copy of the treating physician's final report was provided with the notice, the maximum penalty shall be $100 under this subdivision.

(17) The penalty for each failure to notify an injured employee of the reasons he or she is not entitled to any, or to any further, vocational rehabilitation services, and the procedure for contesting the determination of non-eligibility, as required by California Code of Regulations, title 8, sections 9813(a)(3) and 10131, is $100 if notification was issued more than 10 but not more than 20 days after the determination, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $400 if the notice was issued more than 30 days late, and $500 if the notice was overdue more than 40 days and was not issued at the time the audit subject was notified that the claim was selected for audit.

(18) The penalty for each failure to notify an injured employee that his or her injury may have caused permanent disability and the procedures for evaluating the permanent disability, or of the employer's position that the injury has caused no permanent disability and the employee's remedies, in the manner provided by California Code of Regulations, title 8, beginning with section 9810; is $100 if the notice was issued up to 10 days late, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $400 if the notice was issued more than 30 days late, and $500 if the notice was overdue more than 40 days and was not issued at the time the audit subject was notified that the claim was selected for audit.

(19) The penalty for each failure to notify a claimant of the denial of all death benefits claimed by that person (except a denial limited to all or any of: burial expense, benefits which were due to the injured worker before his or her death, or medical-legal expense), in the manner provided by California Code of Regulations, title 8, beginning with section 9810, is $100 if the notice was issued up to 10 days late, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $400 if the notice was issued more than 30 days late, and $500 if the notice was overdue more than 40 days and was not issued at the time the audit subject was notified that the claim was selected for audit.

(20) The penalty for each failure to send a notice denying liability for all workers' compensation benefits, in accordance with California Code of Regulations, title 8, beginning with section 9810, is $100 if the notice was issued up to 10 days late, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $400 if the notice was issued more than 30 days late, and $500 if the notice was overdue more than 40 days and was not issued at the time the audit subject was notified that the claim was selected for audit.

(21) The penalty for each notice denying liability for all workers' compensation benefits, which was materially misleading, is $500.

The penalty for each materially incomplete denial notice is $100.

(22) The penalty for each termination, interruption or deferral of vocational rehabilitation services other than as provided by Labor Code sections 4637(b) and 4644(b) is $1,000.

(23) The penalty for each failure to comply with, show good cause for non-compliance with, or contest, within 30 days of receipt, any written request or order of the Administrative Director or Audit Unit which is not specified in subdivisions (a)(10), (a)(12), (b)(3), (b)(13), or (b)(24) of this section is:

$500 if there was compliance in more than 30 but not more than 40 days from receipt of the request or order;

$1,000 if there was compliance in more than 40 but not more than 60 days from receipt of the request or order;

$2,500 if there was compliance in more than 60 but not more than 90 days of receipt of the request or order;

$5,000 for failure to comply within 90 days of receipt of the request or order.

(24) The penalty for each failure to fully and/or timely comply with any final award or order of the Workers' Compensation Appeals Board, or the Rehabilitation Unit, or the Administrative Director which is not assessed pursuant to subdivision (a)(10), is:

$100 for each late payment of interest required pursuant to Labor Code section 5800.

$250 for each failure to pay interest required pursuant to Labor Code section 5800.
$500 for compliance (other than a late interest payment) in more than 20 but not more than 35 days from the date of service

$1,000 for compliance (other than a late interest payment) in more than 35 but not more than 60 days from the date of service;

$2,500 for compliance (other than a late interest payment) in more than 60 but not more than 90 days from the date of service;

$5,000 if there was not compliance (other than failure to pay interest) within 90 days of the date of service.

Penalties will be assessed separately for both late compliance and the failure to pay a portion of an award or order. Compliance with an award or order must be within 20 days of service of the award or order, unless the award or order expressly allows additional time, plus an additional five days for service by mail. If additional time for payment is allowed in the award or order, the penalties set forth under this subdivision will be assessed based on the date the payment is ordered due instead of the date of service.

(25) The penalty for each failure by a claims administrator to provide a claim form within one working day of receipt of a request from an injured worker or the worker's agent is:

$100 in addition to those shown below, if the claim form provided to the injured worker is not the current form required by existing regulation;

$500 if the claim form was provided in more than 1 but not more than 5 working days from receipt of the request, if benefits were being provided to the employee at the time of the request;

$1,000 if the claim form was not provided within 5 working days of receipt of the request, if benefits were being provided to the employee at the time of the request;

$3,000 if the claim form was provided in more than 1 but not more than 5 working days from receipt of the request, if benefits were not being provided to the employee at the time of the request;

$5,000 if the claim form was not provided within 5 working days of receipt of the request, if benefits were not being provided to the employee at the time of the request.

(26) The penalty for each failure to comply with California Code of Regulations, title 8, section 10104 is:

$100 if the Annual Report of Inventory or Annual Report of Adjusting Locations was filed not more than 10 days late, and an additional $100 for each additional delay of not more than 10 days, to a maximum penalty of $500 if the Annual Report of Inventory or Annual Report of Adjusting Locations was filed more than 40 days late, and $1,000 if the Annual Report of Inventory or Annual Report of Adjusting Locations was overdue more than 40 days and was not filed at the time the audit subject was notified that the claim was selected for audit.

$500 for each Annual Report of Inventory that overstates or understates the number of claims by 10% or more.

(27) The penalty for each failure to comply with the supplemental job displacement benefit notice requirements of California Code of Regulations, title 8, section 10133.51 is:

(A) $100 for each materially incomplete or inaccurate notice relating to the supplemental job disability benefit;

(B) $100 for each failure to send the notice of supplemental job displacement benefits by certified mail.

(C) For each failure to issue the notice of supplemental job displacement benefits (if not previously issued) within 10 days of the last payment of temporary disability is:

$100 for each failure to issue the notice of supplemental job displacement benefits within 10 days of the last payment of temporary disability if the notice was issued not more than 10 days late.

$200 for each failure to issue the notice of supplemental job displacement benefits if the notice was issued more than

ten but not more than 20 days late;

$300 for each failure to issue the notice of supplemental job displacement benefits if the notice was issued more than 20 but no more than 30 days late;

$400 for each failure to issue the notice of supplemental job displacement benefits if the notice was issued more than 30 but no more than 40 days late;

$500 for each failure to issue the notice of supplemental job displacement if the notice was issued more than 40 days late or was not issued;

(28) For each failure to issue the voucher for education-related retraining/skill enhancement in compliance with California Code of Regulations, title 8, section 10133.56(c), unless the employer meets the conditions set forth in Labor Code section 4658.6, is:

$100 for each failure to issue the voucher, in the manner required by law and regulations, not more than 10 days late;

$200 for each failure to issue the voucher, in the manner required by law and regulations, more than ten but not more than 20 days late;

$300 for each failure to issue the voucher, in the manner required by law and regulations, more than 20 but not more than 30 days late;

$400 for each failure to issue the voucher, in the manner required by the law and regulations, more than 30 but not more than 40 days late;
$500 for each failure to issue the voucher, in the manner required by the law and regulations, more than 40 but not more than 50 days late;

$1000 for each failure to issue the voucher, in the manner required by the law and regulations, within 51 days.

(29) For failure to pay any properly documented supplemental job displacement benefit voucher billing within the time frames required by California Code of Regulations, title 8, section 10133.56(h) is:

$100 for each bill of $1000 or less;

$200 for each bill of more than $1000, but no more than $2000;

$300 for each bill of more than $2000, but no more than $3000;

$500 for each bill of more than $3000, but no more than $5000;

$1000 for each bill of more than $5000.

(30) For claims reported on or after April 19, 2004, regardless of the date of injury, the penalty for each failure to authorize medical treatment for which the employer is responsible under Labor Code section 5402(c) is $2,500.

(c) Mitigation of penalty amounts pursuant to Labor Code section 129.5(b)(1) through (b)(7) will be applied as follows:

(1) Mitigation for gravity of the violation is included within the penalty amounts set forth in subdivisions (a) and (b).

(2) Mitigation for good faith of the insurer, self-insured employer, or third-party administrator will be determined based on documentation of attempts to comply with requirements of the Labor Code and the Administrative Director's regulations, and will result in a reduction of 20% for each applicable violation. Penalties may be mitigated for good

faith in an amount greater than 20% in extraordinary circumstances, when strict application of this mitigation guideline would be clearly inequitable.

(3) Mitigation for frequency is considered as included within the numbers of penalties and their amounts established by this section and in conjunction with the frequency of violations that determines whether or not the audit subject meets or exceeds the profile audit review performance standards and/or full compliance audit performance standards pursuant to sections 10107.1(c)(3) and (d)(3).

(4) Mitigation for history shall be determined as follows:

(A) For audits that meet or exceed the full compliance audit performance standard, penalty amounts will be reduced by 20%, after modification for good faith, if any, in instances in which the audit subject met or exceeded the profile audit review performance standards in the audit preceding the current audit. No reduction shall apply if the preceding audit occurred before January 1, 2003.

(B) For audits that fail to meet or exceed the full compliance audit performance standards, mitigation for history shall be determined pursuant to Labor Code section 129.5(e).

(5) Mitigation based on whether or not the audit subject has met or exceeded the profile audit review performance standard is determined pursuant to Labor Code section 129.5(c) (1) and (c)(2).

(6) Mitigation based on whether or not the audit subject has met or exceeded the full compliance audit performance standard is determined pursuant to Labor Code section 129.5(c)(3).

(7) Consideration of penalty amounts based on the size of the audit subject location pursuant to Labor Code section 129.5(c)(3) shall be based on the number of indemnity claims reported at the audit subject's location for the most recent complete calendar year. For an audit subject location that is handling only run-off claims, the penalty amount shall be based on the number of open run-off claims and claims that were closed at the audit subject location in the most recent complete calendar year. For audit subjects that fail to meet or exceed the full compliance audit performance standards calculated pursuant to section 10107.1(d)(3), after penalty amounts are calculated pursuant to subdivisions (a)(1) through (c)(6) of this section, penalty amounts will be modified based on the size of the adjusting location as follows:

Number of indemnity claims reported at the audit subject location in most recent complete calendar year:	Multiply the penalty amount calculated pursuant to subdivisions (a)(1) through (c)(6) of this section by the following factor:
Less than 65:	1.0
65-99	1.2
100-249	1.4
250-499	1.6
500-749	1.8
750-999	2.0
1,000-1,499	2.4
1,500-1,999	2.8
2,000-3,499	3.6
3,500 or more	7.2

(8) The Audit Unit may assess penalties pursuant to subdivisions (a), (b), and (c) in target audits in which the claims were audited to evaluate specific practices but in which full compliance audit samples of claims were not randomly selected pursuant to Section 10107.1(c) through (e).

Note: Authority cited: Sections 59, 129, 129.5, 133, 138.3, 138.4, 138.6, 138.7, 139.5, 4603.5, 4610, 4627, 4658.5, 4658.6 and 5307.3, Labor Code. Reference: Sections 124, 129, 129.5, 138.6, 138.7, 4061, 4453, 4454, 4550, 4600, 4603.2, 4610, 4621, 4622, 4625, 4636-4638, 4639, 4641, 4642, 4650, 4658.5, 4658.6, 4701-4703.5, 4706, 4706.5, 4951, 5401, 5401.6, 5402, 5800 and 5814, Labor Code; and Section 2629.1(e) and (f), Unemployment Insurance Code.

HISTORY

1. New section filed 12-30-2002; operative 1-1-2003 pursuant to GovernmentCode section 11343.4 (Register 2003, No. 1).

2. Change without regulatory effect amending subsection (b)(8)[iv] filed 5-1-2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 18).

3. Amendment of subsections (a)(1) and (a)(8), new subsection (a)(9), subsection renumbering, amendment of newly designated subsections (a)(10)-(11) and subsection (b)(23), new subsection (b)(24) and subsection renumbering filed 10-6-2003; operative 12-1-2003 (Register 2003, No. 41).

4. Amendment of section and Note filed 4-20-2009; operative 5-20-2009 (Register 2009, No. 17).

5. Change without regulatory effect amending subsection (a)(9) filed 12-9-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 50).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 5. Administrative Penalties

New query

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§10112. Liability for Penalty Assessments.

The audit subject is liable for all penalty assessments, except that if the audit subject is acting as a third-party administrator, the client of that third-party administrator which secures the payment of compensation is jointly and severally liable with the administrator for all penalty assessments except civil penalties imposed under Labor Code section 129.5(e). Without affecting DWC's rights, a third-party administrator and its client may agree how to allocate the audit penalty expense between them.

Note: Authority cited: Sections 59, 129.5, 133. 5307.3, Labor Code. Reference: Section 129, 129.5, 3200-6002, Labor Code.

HISTORY

1. Renumbering of former section 10112 to section 10115 and new section filed 1-28-94; operative 1-28-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 94, No. 4).

2. Amendment filed 4-20-2009; operative 5-20-2009 (Register 2009, No. 17).

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DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
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SUBCHAPTER 1.5. INJURIES ON OR AFTER JANUARY 1, 1990
ARTICLE 5.5. ADMINISTRATIVE PENALTIES PURSUANT TO LABOR CODE SECTION 5814.6

New query

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§ 10112.1. Definitions.

(a) "Adjusting location" means the office where claims are administered. Separate underwriting companies, employers that are both self-administered and self-insured, and/or third-party administrators operating at one location shall be combined as one adjusting location only if claims are administered under the same management at that location. Where claims are administered from an office that includes a satellite office at another location, claims administered at the satellite office(s) will be considered as part of the single adjusting location for investigation and auditing purposes under this article when it is demonstrated that the claims are under the same immediate management.

(b) "Administrative Director" means the Administrative Director of the Division of Workers Compensation, including his or her designee.

(c) "Claim" means a request for compensation, or record of an occurrence in which compensation reasonably would be expected to be payable for an injury arising out of and in the course of employment.

(d) "Claim file" means a record in paper or electronic form, or any combination, containing all of the information specified in section 10101.1 of Title 8 of the California Code of Regulations and all documents or entries related to the provision, payment, delay, or denial of benefits or compensation under Divisions 1, 4 or 4.5 of the Labor Code.

(e) "Claims administrator" means a self-administered workers' compensation insurer; a self-administered self-insured employer; a self-administered legally uninsured employer; a self-administered joint powers authority; or a third-party claims administrator for an insurer, a self-insured employer, a legally uninsured employer or a joint powers authority.

(f) "Compensation" means every benefit or payment, including vocational rehabilitation, supplemental job displacement benefits, medical treatment, medical and medical-legal expenses, conferred by Divisions 1 and 4 of the Labor Code on an injured employee or the employee's dependents.

(g) "Compensation order" means any award, order or decision issued by the Workers' Compensation Appeals Board or the Division of Workers' Compensation vocational rehabilitation unit by which a party is entitled to payment of compensation.

(h) "Concurrent medical treatment authorization" means authorization requested or provided during an inpatient stay.

(i) " Determination and Order" means Determination and Order in re Labor Code § 5814.6 Administrative Penalties.

(j) "Employee" means every person in the service of another, as defined under Article 2 of Chapter 2 of Part 1 of Division 4 of the Labor Code (Sections 3350 et seq.), or in the case of the employee's death, his or her dependent, as each is defined in Division 4 of the Labor Code, or the employee's or dependent's agent or attorney.

(k) "Employer" shall have the same meaning as the word 'employer' as defined in Division 4 of the Labor Code (sections 3300 et seq.).

(l) "General business practice" means a pattern of violations of Labor Code section 5814 at a single adjusting location that can be distinguished by a reasonable person from an isolated event. The pattern of violations must occur in the handling of more than one claim. The pattern of violations may consist of one type of act or omission, or separate, discrete acts or omissions in the handling of more than one claim. However, where a claim file with a violation of Labor Code section 5814 has been adjusted at multiple adjusting locations, that claim file may be considered when determining the general business practice of any of the adjusting locations where the conduct that caused the violation occurred even if the file has been transferred to a different adjusting location.

(m) "Indemnity" means payments made directly to an eligible person as a result of a work injury and as required under Division 4 of the Labor Code, including but not limited to temporary disability indemnity, salary continuation in lieu of temporary disability indemnity, permanent disability indemnity, vocational rehabilitation temporary disability indemnity, vocational rehabilitation maintenance allowance, life pension and death benefits.

(n) "Insurer" means any company, group, or entity in, or which has been in, the business of transacting workers' compensation insurance for one or more employers subject to the workers' compensation laws of this state. The term insurer includes the State Compensation Insurance Fund.

(o) "Investigation" means the process used by the Administrative Director, or his or her designee, pursuant to Section 10112.2 and/or Government Code sections 11180 through 11191, to determine whether a violation of Labor Code section 5814.6 has occurred, including but not limited to reviewing, evaluating, copying and preserving electronic and paper records, files, accounts and other things, and interviewing potential witnesses.

(p) "Joint powers authority" means any county, city, city and county, municipal corporation, public district, public agency, or political subdivision of the state, but not the state itself, included in a pooling arrangement under a joint exercise of powers agreement for the purpose of securing a certificate of consent to self-insure workers' compensation claims under Labor Code Section 3700(c).

(q) "Knowingly" means acting with knowledge of the facts of the conduct at issue. For the purposes of this article, a corporation has knowledge of the facts an employee receives while acting within the scope of his or her authority. A corporation has knowledge of information contained in its records and of the actions of its employees performed in the scope and course of employment. An employer or insurer has knowledge of information contained in the records of its third-party administrator and of the actions of the employees of the third-party administrator performed in the scope and course of employment.

(r) "Notice of Assessment" means Notice of Labor Code § 5814.6 Administrative Penalty Assessment.

(s) "Penalty award" means a final order or final award by the Workers' Compensation Appeals Board to pay penalties due to a violation of section 5814 of the Labor Code.

(t) "Petition Appealing Determination and Order" means Petition Appealing Determination and Order of the Administrative Director in re Labor Code § 5814.6 Administrative Penalties.

(u) "Proof of service" means an affidavit or declaration made under penalty of perjury and filed with one or more documents required to be filed, setting out a description of the document(s) being served, the names and addresses of all persons served, whether service was made personally or by mail, the date of service, and the place of service or the address to which mailing was made.

(v) "Prospective medical treatment authorization" means authorization requested or provided prior to the delivery of the medical services.

(w) "Recommended Determination and Order" means Recommended Determination and Order in re Labor Code §

(x) "Retrospective medical treatment authorization" means authorization requested or provided after medical services have been provided and for which services approval has not already been given.

(y) "Salary continuation" means payment made to an injured employee as provided under Division 4 of the Labor Code.

(z) "Serve" means to file or deliver a document or to cause it to be delivered to the Administrative Director or his or her designee, or to such other person as is required under this article.

(aa) "Stipulated Order" means a Notice of Assessment that was timely paid.

(bb) "Supplemental job displacement benefits" means benefits as described under Labor Code section 4658.5 and sections 10133.50-10133.59 of Title 8 of the California Code of Regulations.

(cc) "Third-party administrator" means an agent under contract to administer the workers' compensation claims of an insurer, a self-insured employer, a legally uninsured employer, a self-insured joint powers authority or on behalf of the California Insurance Guarantee Association. The term third-party administrator includes the State Compensation Insurance Fund for locations that administer claims for legally uninsured and self-insured employers, and also includes managing general agents.

(dd) "Utilization review files" means those files, documents or records, whether paper or electronic, containing information that documents an employer or insurer utilization review process required under Division 4 of the Labor Code.

(ee) "Workers' Compensation Appeals Board" means the Appeals Board, commissioners, deputy commissioners, presiding workers' compensation judges and workers' compensation administrative law judges.

Note: Authority cited: Sections 133, 5307.3 and 5814.6, Labor Code. Reference: Sections 129.5, 139.48, 5814 and 5814.6, Labor Code.

HISTORY

1. Change without regulatory effect renumbering former subchapter 1.8, article 1 (sections 10225-10225.2) to subchapter 1.5, article 5.5 (sections 10112.1-10112.3) and renumbering former section 10225 to section 10112.1 filed 4-7-2008 pursuant to section 100, title 1, California Code of Regulations (Register 2008, No. 15).

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New query

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§ 10112.2. Schedule of Administrative Penalties Pursuant to Labor Code §5814.6.

(a) Administrative penalties shall only be imposed under this section based on violations of Labor Code section 5814, after more than one penalty award has been issued by the Workers' Compensation Appeals Board on or after June 1, 2004 based on conduct occurring on or after April 19, 2004 for unreasonable delay or refusal to pay compensation within a five year time period. The five year period of time shall begin on the date of issuance of any penalty award not previously subject to an administrative penalty assessment pursuant to Labor Code section 5814.6.

(b) The Division of Workers' Compensation shall at least monthly submit copies of WCAB decisions, findings, and/or awards issued pursuant to Labor Code section 5814 to the Audit Unit.

(c) The Audit Unit shall obtain monthly Labor Code section 5814 activity reports and shall determine if the decisions, findings, and/or awards are final. If more than one final penalty award has been issued on or after June 1, 2004 against a claims administrator at a single adjusting location, the Audit Unit may proceed with an investigation.

(d) To determine whether a violation described in Labor Code section 5814.6 has occurred, and notwithstanding Labor Code section 129(a) through (d) and section 129.5 subdivisions (a) through (c) and sections 10106, 10106.1, 10107 and 10107.1 of Title 8 of the California Code of Regulations, the Administrative Director, or his or her designee, may conduct an investigation, which may include but is not limited to an audit of claims and/or utilization review files. The investigation may be independent of, or may be conducted concurrently with, an audit conducted pursuant to Labor Code section 129 and 129.5.
(e) The Administrative Director, or his or her designee, may also utilize the provisions of Government Code sections 11180 through 11191 to carry out the responsibilities mandated by Labor Code section 5814.6.

(f) The Administrative Director may issue a Notice of Assessment under this article in conjunction with an order to show cause pursuant to section 10113 of Title 8 of the California Code of Regulations, charging both an administrative penalty under this section and a civil penalty under subdivision (e) of Labor Code section 129.5 in the same pleading, however only one penalty may be imposed by the Administrative Director following the hearing on such charges.

(g) Pursuant to Labor Code section 5814.6, the Administrative Director, or his or her designee, shall issue a Notice of Assessment for administrative penalties against an employer and/or insurer as follows:

(1) $ 100,000 for when the Administrative Director, or his or her designee, has evidence to support a finding that an employer or insurer knowingly violated Labor Code section 5814 with a frequency that indicates a general business practice, and additionally for each applicable penalty award, the following;

(2) $ 30,000 for each penalty award by the Workers' Compensation Appeals Board for a violation of Labor Code section 5814 for an unreasonable delay or refusal to comply with an existing compensation order;

(3) For each penalty award by the Workers' Compensation Appeals Board for a violation of Labor Code section 5814 for an unreasonable delay or refusal to make a payment of temporary disability benefits or salary continuation payments in lieu of temporary disability; vocational rehabilitation maintenance allowance, life pension, or death benefits:

(A) $ 5,000 for 14 days or less of indemnity benefits;

(B) $ 10,000 for 15 days through 42 days of indemnity benefits;

(C) $ 15,000 for more than 42 days of indemnity benefits.

(4) For each penalty award by the Workers' Compensation Appeals Board for a violation of Labor Code section 5814 for an unreasonable delay or refusal to provide authorization for medical treatment:

(A) $ 1,000 for retrospective medical treatment authorization;

(B) $ 5,000 for prospective or concurrent medical treatment authorization;

(C) $15,000 for prospective or concurrent medical treatment authorization when the employee's condition is such that the employee faces an imminent and serious threat to his or her health.

(5) For each penalty award by the Workers' Compensation Appeals Board for a violation of Labor Code section 5814 for an unreasonable delay or refusal to reimburse an employee for self-procured medical treatment costs:

(A) $ 1,000 for medical treatment costs of $100 or less, excluding interest and penalty;

(B) $ 2,000 for medical treatment costs of more than $100 to $300, excluding interest and penalty;

(C) $ 3,000 for medical treatment costs of more than $300 to $500, excluding interest and penalty;

(D) $ 5,000 for medical treatment costs of more than $500, excluding interest and penalty.

(6) $ 2,500 for each penalty award by the Workers' Compensation Appeals Board for a violation of Labor Code section 5814 for an unreasonable delay or refusal to provide the the supplemental job displacement benefit, as required by section 10133.51(b) and section 10133.56(c), respectively, of Title 8 of the California Code of Regulations.

(7) $ 2,500 for each penalty award by the Workers' Compensation Appeals Board for a violation of Labor Code

section 5814 for an unreasonable delay or refusal to make payment to an injured worker as reimbursement for payment for services provided for a supplemental job displacement benefit voucher, or where the unreasonable delay or refusal to pay the training provider causes an interruption in the employee's retraining.

(8) For each penalty award by the Workers' Compensation Appeals Board for a violation of Labor Code section 5814 for an unreasonable delay or refusal to make a payment of permanent disability indemnity benefits:

(A) $ 1,000 for 15 weeks or less of indemnity benefits;

(B) $ 5,000 for more than 15 but not more than 50 weeks of indemnity benefits;

(C) $ 7,500 for more than 50 but not more than 95 weeks of indemnity benefits;

(D) $ 15,000 for more than 95 weeks of indemnity benefits.

(9) $ 2,500 for any other penalty award by the Workers' Compensation Appeals Board pursuant to Labor Code section 5814 not otherwise specified in this section.

(h) In cases that the Administrative Director deems appropriate, the Administrative Director, or his or her designee, may mitigate a penalty imposed under this section after considering each of these factors:

(1) The consequences and gravity of the violation(s).

(2) The good faith of the claims administrator.

(3) The history of previous penalty awards under Labor Code section 5814.

(4) The number and type of the violations.

(5) The time period in which the violations occurred.

(6) The size of the claims adjusting location.

(i) Each administrative penalty assessed under this section shall be doubled upon a second Order (which may be a Stipulated Order or a final Determination and Order) by the Administrative Director under Labor Code § 5814.6 against the same employer or insurer within a five (5) year period. Each administrative penalty under this section shall be tripled upon a third Order (which may be a Stipulated Order or a final Determination and Order) by the Administrative Director under Labor Code § 5814.6 against the same employer or insurer within the same five (5) year period.

(j) In no event shall the administrative penalties assessed against a single employer or insurer in a single Stipulated Order or final Determination and Order after doubling or tripling exceed $400,000.

Note: Authority cited: Sections 133, 5307.3 and 5814.6, Labor Code. Reference: Sections 129.5, 139.48, 5814 and 5814.6, Labor Code; and Sections 11180-11191, Government Code.

HISTORY

1. Change without regulatory effect former section 10225.1 to section 10112.2 filed 4-7-2008 pursuant to section 100, title 1, California Code ofRegulations (Register 2008, No. 15).

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New query

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§10112.3. Notice of Administrative Penalty Assessment, Appeal Hearing Procedures and Review.

(a) Pursuant to Labor Code section 5814.6, the Administrative Director shall issue a Notice of Assessment when the Administrative Director, or his or her designee (the investigating unit of the Division of Workers Compensation), has evidence to support a finding that an employer or insurer has knowingly violated section 5814 with a frequency that indicates a general business practice.

(b) Successor liability may be imposed on a corporation or other business entity that has merged with, consolidated with, or otherwise continued the business of an employer or insurer that is subject to penalties under Labor Code section 5814.6. The surviving entity shall assume and be liable for all the liabilities, obligations and penalties of the prior employer or insurer. Successor liability will be imposed if there has been a substantial continuity of business operations and/or the new business uses the same or substantially the same work force.

(c) The Notice of Assessment shall be in writing and shall contain all of the following:

(1) The basis for the penalty assessment, including a statement of the alleged violations and the amount of each proposed penalty;

(2) A description of the methods for paying or appealing the penalty assessment.

(d) The Notice of Assessment shall be served personally or by registered or certified mail.

(e) Within thirty (30) calendar days after the date of service of the Notice of Assessment, the employer or insurer may pay the penalties as assessed or file an appeal with the Administrative Director.

(f) If the employer or insurer pays the penalties within thirty (30) calendar days, the Notice of Assessment shall be deemed a Stipulated Order.

(g) If the employer or insurer files an appeal of the Notice of Assessment with the Administrative Director, the appeal shall:

(1) Admit or deny, in whole or in part any of the allegations set forth in the Notice;

(2) Appeal the existence of any or all of the alleged violations;

(3) Appeal the amount of any or all the penalties assessed;

(4) Set forth any affirmative and other defenses;

(5) Set forth the legal and factual bases for each defense and each ground for appeal. Any item listed in the Notice of Assessment but not appealed shall be paid within thirty (30) calendar days after the date of service of the Notice of Assessment.

(h) Failure to timely file an appeal shall constitute a waiver of the appellant's right to an evidentiary hearing. Unless set forth in the appeal, all defenses to the Notice of Assessment shall be deemed waived. The appellant may also file a written request for leave to assert additional defenses which the Administrative Director may grant upon a showing of good cause.

(i) The appeal shall be in writing signed by, or on behalf of, the employer or insurer, and shall state the appellant's mailing address. The appeal shall be verified, under penalty of perjury, by the employer or insurer. If the appellant is a corporation, the verification may be signed by an officer of the corporation. In the event the appellant is not the employer, the employer's address shall be provided and the employer shall be included on the proof of service.

(1) The appellant shall file the original and one copy of the appeal on the Administrative Director and concurrently serve one copy of the appeal on the investigating unit of the Division of Workers Compensation designated by the Administrative Director. The original and all copies of any filings required by this section shall have a proof of service attached.

(j) At any time before the hearing, the Administrative Director may file or permit the filing of an amended Notice of Assessment. All parties shall be notified thereof. If the amended Notice of Assessment presents new allegations or new penalties, the Administrative Director shall afford the Appellant a reasonable opportunity to prepare its defense, and the Appellant shall be entitled to file an amended appeal.

(k) At the Administrative Director's discretion, the Administrative Director may proceed with an informal pre-hearing conference with the appellant in an effort to resolve the contested matters. If any or all of the proposed penalties in Notice of Assessment or the amended Notice of Assessment remain contested, those contested matters shall proceed to an evidentiary hearing.

(l) Whenever the Administrative Director's Notice of Assessment has been contested, the Administrative Director may designate a hearing officer to preside over the hearing. The authority of the Administrative Director or any designated hearing officer includes, but is not limited to: conducting a prehearing settlement conference; setting the date for an evidentiary hearing and any continuances; issuing subpoenas for the attendance of any person residing anywhere within the state as a witness or party at any pre-hearing conference and hearing; issuing subpoenas duces tecum for the production of documents and things at the hearing; presiding at hearings; administering oaths or affirmations and certifying official acts; ruling on objections and motions; issuing prehearing orders; and preparing a Recommended Determination and Order based on the hearing.

(m) The Administrative Director, or the designated hearing officer, shall set the time and place for any prehearing conference on the contested matters in a Notice of Hearing and shall give sixty (60) calendar days written notice to all parties.

(n) The prehearing conference may address one or more of the following matters:

(1) Exploration of settlement possibilities.

(2) Preparation of stipulations.

(3) Clarification of issues.

(4) Rulings on identity and limitation of the number of witnesses.

(5) Objections to proffers of evidence.

(6) Order of presentation of evidence and cross-examination.

(7) Rulings regarding issuance of subpoenas and protective orders.

(8) Schedules for the submission of written briefs and schedules for the commencement and conduct of the hearing.

(9) Any other matters as shall promote the orderly and prompt conduct of the hearing.

(o) The Administrative Director, or the designated hearing officer, shall issue a prehearing conference order incorporating the matters determined at the prehearing conference. The Administrative Director, or the designated hearing officer, may direct one or more of the parties to prepare the prehearing conference order.

(p) Not less than 30 calendar days prior to the date of the pre-hearing conference, or if no pre-hearing conference is set, not less than 30 calendar days prior to the date of the evidentiary hearing, the Appellant shall file and serve the original and one copy of a written statement with the Administrative Director, or the designated hearing officer, specifying the legal and factual bases for its appeal and each defense, listing all witnesses the Appellant intends to call to testify at the hearing, and appending copies of all documents and other evidence the Appellant intends to introduce into evidence at the hearing. A copy of the written statement and its attachments shall also concurrently be served on the investigating unit of the Division of Workers' Compensation. If the Appellant's written statement and supporting evidence are not timely filed and served, the Administrative Director, or the designated hearing officer , shall dismiss the appeal and the violations and penalties as stated in the Notice of Assessment shall be final, due and payable. Within ten (10) calendar days of the date for filing the written statement and supporting evidence, the Appellant may file a written request for leave to file a written statement and supporting evidence. The Administrative Director, or the designated hearing officer, may grant the request, upon a showing of good cause. If leave is granted, the written statement and supporting evidence must be filed and served no later than ten (10) calendar days prior to the date of the hearing.

(q) Oral testimony shall be taken only on oath or affirmation.
(r)(1) Each party shall have these rights: to call and examine witnesses, to introduce exhibits; to cross-examine opposing witnesses on any matter relevant to the issues even though that matter was not covered in the direct examination; to impeach any witness regardless of which party first called him or her to testify; and to rebut the evidence.

(2) In the absence of a contrary order by the Administrative Director, or the designated hearing officer, the investigating unit of the Division of Worker's Compensation shall present evidence first.

(3) The hearing need not be conducted according to the technical rules relating to evidence and witnesses, except as hereinafter provided. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible

persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of the evidence over objection in civil actions.

(4) Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions. An objection is timely if made before submission of the case to the Administrative Director, or to the designated hearing officer.

(s) The written affidavit or declaration of any witness may be offered and shall be received into evidence provided that (i) the witness was listed in the written statement pursuant to section 10112.3(p), (ii) the statement is made by affidavit or by declaration under penalty of perjury, (iii) copies of the statement have been delivered to all opposing parties at least 20 calendar days prior to the hearing, and (iv) no opposing party has, at least 10 calendar days before the hearing, delivered to the proponent of the evidence a written demand that the witness be produced in person to testify at the hearing. The Administrative Director, or the designated hearing officer, shall disregard any portion of the statement received pursuant to this regulation that would be inadmissible if the witness were testifying in person, but the inclusion of inadmissible matter does not render the entire statement inadmissible. Upon timely demand for production of a witness in lieu of admission of an affidavit or declaration, the proponent of that witness shall ensure the witness appears at the scheduled hearing and the proffered declaration or affidavit from that witness shall not be admitted. If the Administrative Director, or the designated hearing officer, determines that good cause exists that prevents the witness from appearing at the hearing, the declaration may be introduced in evidence, but it shall be given only the same effect as other hearsay evidence.

(t) The Administrative Director, or the designated hearing officer, shall issue a written Recommended Determination and Order, granting or denying the appeal, in whole or part, and affirming or amending the penalty assessment(s). The Recommended Determination and Order shall include a statement of the basis for the decision and each penalty assessed. It shall be served on all parties within sixty (60) calendar days of the date the case was submitted for determination. This requirement is directory and not jurisdictional.

(u) The Administrative Director shall have up to sixty (60) calendar days to adopt or modify the Recommended Determination and Order issued by the Administrative Director or the designated hearing officer. In the event the Recommended Determination and Order is modified, the Administrative Director shall include a statement of the basis for the Determination and Order. If the Administrative Director does not act within sixty (60) calendar days, then the Recommended Determination and Order shall become the Determination and Order on the sixty-first calendar day.

(v) The Determination and Order shall be served on all parties personally or by registered or certified mail by the Administrative Director.

(w) The Determination and Order, if any, shall become final on the date it was served, unless the aggrieved party files a timely Petition Appealing Determination and Order within twenty (20) days. A timely filed Petition Appealing the Determination and Order tolls the period for paying any disputed penalty. All findings and assessments in the Determination and Order that are not contested in the Petition Appealing Determination and Order shall become final as though no such petition was filed.

(x) At any time prior to the date the Determination and Order becomes final, the Administrative Director may correct the Determination and Order for clerical, mathematical or procedural error.

(y) Penalties assessed in a Determination and Order shall be paid within thirty (30) calendar days of the date the Determination and Order has been served, if no Petition Appealing Determination and Order has been filed. The penalties shall be deposited into the Return-to-Work-Fund.

(z) All appeals from any part or the entire Determination and Order shall be made in the form of a Petition Appealing the Determination and Order, in conformance with the requirements of chapter 7, part 4 of Division 4 of the Labor

Code. Any such Petition Appealing the Determination and Order shall be filed at the Workers' Compensation Appeals Board in San Francisco (and not with any district office of the Workers' Compensation Appeals Board), in the same manner specified for petitions for reconsideration.

Note: Authority cited: Sections 133, 5307.3 and 5814.6, Labor Code. Reference: Sections 129.5, 139.48, 5300, 5814, 5814.6 and 5900 et seq., Labor Code.

HISTORY

1. Change without regulatory effect former section 10225.2 to section 10112.3, including amendment of subsection (s), filed 4-7-2008 pursuant to section100, title 1, California Code of Regulations (Register 2008, No. 15).

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Subchapter 1.5. Injuries on or After January 1, 1990
Article 6. RETRAINING AND RETURN TO WORK -DEFINITIONS AND GENERAL PROVISIONS

New query

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§10116. Applicability of Article.

The provisions of this article are applicable to Articles 6.5, 7, and 7.5 of these regulations, except for the definitions in section 10116.9. The definitions in section 10116.9 only apply to the provisions of Articles 6.5 and 7.5.

Note: Authority cited: Sections 111, 133, 5307.3 and 5307.4, Labor Code. Reference: Sections 139.5, 4658, 4658.1, 4658.5 and 4658.6, Labor Code.

HISTORY

1. New article 6 (sections 10116-10116.9) and section filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47). For prior history of article 6, see Register 2008, No. 15, renumbering article 6, sections 10116-10121 to article 9, sections 10136-10142.

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 6. RETRAINING AND RETURN TO WORK -DEFINITIONS AND GENERAL PROVISIONS

New query

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§10116.1. Filing and Reporting Requirements.

(a) "Electronic Adjudication Management System" or "EAMS" means the computer case management system used by the Division of Workers' Compensation to electronically store and maintain the Division of Workers' Compensation or appeals board's case files and to perform other case management functions.

(b) All forms, documents or correspondence submitted to the Retraining and Return to Work Unit shall be signed by the filing party and stored in the EAMS:

(1) Except for documents or forms which open a Retraining and Return to Work Unit file, all documents and forms shall contain a case number assigned by the Division of Workers' Compensation.

(2) Case opening documents shall be assigned a case number by the Division of Workers' Compensation after filing where no case number has been previously assigned for the date of injury alleged by the injured worker. The case number shall be preceded by the prefix "VOC" for cases governed by Article 7 of these rules and "RSU" for cases governed by Article 6.5 and 7.5 of these rules. If a case number has been previously assigned by the Division of Workers' Compensation, the prefix "VOC" or "RSU" shall precede the assigned case number on a form or document filed with the Retraining and Return to Work Unit. Documents or forms filed in existing cases without a case number will be returned to the sender with instructions for proper filing.

(3) All documents presented for filing shall conform to the requirements of sections 10217, 10228 and 10232 of title 8 of the California Code of Regulations.

(4) The Division of Workers' Compensation shall scan all documents and forms filed into the EAMS case file and then the paper document or form will be destroyed not less than 30 business days after filing. A properly filed form or document shall be deemed a legal filing for all purposes.

(5) The service of all documents and forms shall conform to the methods of service described in section of 10218 of title 8 of the California Code of Regulation.

(c) All required notices, any documents or forms shall be sent to the employee and his or her attorney, if any, on a

timely basis by the claims administrator in the form and manner prescribed in section 10218 of title 8 of the California Code of Regulation. Failure to provide notices timely shall subject the insurer, third party administrator or self-insured employer to administrative or civil penalties. The notices are timely when sent according to the requirements of sections 9813, 9813.1 and 9813.2 of title 8 of the California Code of Regulation.

Note: Authority cited: Sections 133, 139.48, 139.5, 4658, 4658.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code; Godinez v. Buffets, Inc. (2004, Significant Panel Decision) 69 Cal. Comp. Cases 1311; and Vulean Materials Co. v. WCAB (2006, Writ Denied) 71 Cal. Comp. Cases 1346.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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Chapter 4.5. Division of Workers' Compensation
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New query

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§10116.2. Electronic Filing Exemption.

If a document is filed with EAMS as part of the electronic filing trial, that document does not need to be filed in compliance with sections 10228 and 10232 of title 8 of the California Code of Regulation.

Note: Authority cited: Sections 111, 133, 5307.3 and 5307.4, Labor Code. Reference: Sections 124 and 126, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§ 10116.3. Incomplete Filings.

(a) A form filed without the attachments or enclosures required by these rules is deemed incomplete and shall not be deemed filed for any purpose. All incomplete requests will be date stamped by the Division of Workers' Compensation.

(b) The Retraining and Return to Work Unit shall notify the filer and the other parties when a form or document is deemed not filed.

(c) Forms including filing instructions and venue lists shall be provided upon request by the Retraining and Return to Work Unit. Requests shall be submitted to:

RETRAINING AND RETURN TO WORK UNIT HEADQUARTERS
P. O. BOX 420603
SAN FRANCISCO, CA 94142

Or may be found at http://www.dir.ca.gov/dwc/forms.html
Note: Authority cited: Sections 133, 139.48, 139.5, 4658, 4658.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code; Godinez v. Buffets, Inc.(2004, Significant Panel Decision) 69 Cal. Comp. Cases 1311; and Vulean Materials Co. v. WCAB (2006, Writ Denied) 71 Cal. Comp. Cases 1346.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§ 10116.4. Reproduction of Forms, Notices. (Repealed)

HISTORY

1. Renumbering of former section 10123.1 to new section 10116.4, including amendment of section and new Note, filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

2. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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New query

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§10116.5. Technical Problems and Unavailability of EAMS.

Technical problems with filing documents shall be governed by sections 10223 and 10225 of title 8 of the California Code of Regulation.

Note: Authority cited: Sections 133, 139.48, 139.5, 4658, 4658.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code; Godinez v. Buffets, Inc.(2004, Significant Panel Decision) 69 Cal. Comp. Cases 1311; and Vulean Materials Co. v. WCAB (2006, Writ Denied) 71 Cal. Comp. Cases 1346.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10116.6. Retraining and Return to Work File Retention.

(a) Following a period of fifty (50) years after the filing of a document used to open a case or file, the Division of Workers' Compensation may destroy the electronic and/or paper file in each case maintained by the Retraining and Return to Work Unit.

(b) The Division of Workers' Compensation, at any time, may convert a paper file to an electronic file. The Division of Workers' Compensation shall inform the parties when a paper file is converted. If a paper case file has been converted to electronic form, the paper case file may be destroyed no less than 30 business days after the parties have been informed of the conversion.

Note: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§ 10116.7. Misfiled or Misdirected Documents.

(a) A request to move, substitute, or correct a document shall be made in conformity with section 10223 of title 8 of the California Code of Regulation, except that a request to substitute shall be made in lieu of a petition to substitute as allowed under section 10223(b). The authority to approve moving a document from one file to another file shall reside with the Manager of the Retraining and Return to Work Unit or his or her designee.

(b) If a document is not filed in compliance with sections 10217, 10228 and 10232 of title 8 of the California Code of Regulations and these regulations, the administrative director may in his or her discretion take the actions set forth in section 10222 of title 8 of the California Code of Regulations.

Note: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10116.8. Jurisdiction Where the Issue of Injury Has Not Been Resolved.

(a) No forms, notices or reports shall be filed with the Retraining and Return to Work Unit until the claims administrator has accepted liability for the injury or there has been a finding of compensable injury by the appeals board.

(b) Any requests for provision of retraining or return to work services and for intervention/dispute resolution require confirmation on the appropriate form by the employee or his/her representative that liability for the injury has been accepted.
(c) Forms sent to the Retraining and Return to Work Unit when a good faith issue of injury exists or where there has been no confirmation of acceptance of liability for the injury shall be returned to the sender.
Note: Authority cited: Sections 133, 139.48, 139.5, 4658, 4658.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code; Godinez v. Buffets, Inc.(2004, Significant Panel Decision) 69 Cal. Comp. Cases 1311; and Vulean Materials Co. v. WCAB (2006, Writ Denied) 71 Cal. Comp. Cases 1346.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10116.9. Definitions for Article 6.5 and 7.5.

The following definitions apply to the provisions of Article 6.5 and 7.5 governing injuries occurring on or after January 1, 2004:

(a) "Alternative work" means work (1) offered either by the employer who employed the injured worker at the time of injury, or by another employer where the previous employment was seasonal work, (2) that the employee has the ability to perform, (3) that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury, and (4) that is located within a reasonable commuting distance of the employee's residence at the time of injury.

(b) "Approved training facility" means a training or skills enhancement facility or institution that meets the requirements of section 10133.58.

(c) "Claims administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, a self-administered joint powers authority, a self-administered legally uninsured, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(d) "Employer" means the person or entity that employed the injured employee at the time of injury.

(e) "Essential functions" means job duties considered crucial to the employment position held or desired by the employee. Functions may be considered essential because the position exists to perform the function, the function requires specialized expertise, serious results may occur if the function is not performed, other employees are not available to perform the function or the function occurs at peak periods and the employer cannot reorganize the work flow.

(f) "Insurer" has the same meaning as in Labor Code section 3211.

(g) "Modified work" means regular work modified so that the employee has the ability to perform all the functions of the job and that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury, and located within a reasonable commuting distance of the employee's residence at the time of injury.

(h) "Nontransferable training voucher" means a document provided to an employee that allows the employee to enroll in education-related training or skills enhancement. The document shall include identifying information for the employee and claims administrator, and specific information regarding the value of the voucher pursuant to Labor Code section 4658.5.

(i) "Notice" means a required letter or form generated by the claims administrator and directed to the injured employee.

(j) "Offer of modified or alternative work" means an offer to the injured employee of medically appropriate employment with the date-of-injury employer through the use of Form DWC-AD 10133.53, Notice of Offer of Modified or Alternative Work.

(k) "Parties" means the employee, the claims administrator and their designated representatives, if any.

(l) "Permanent and stationary" means the point in time when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment, based on (1) an opinion from a treating physician, AME, or QME; (2) a judicial finding by a Workers' Compensation Administrative Law Judge, the Workers' Compensation Appeals Board, or a court; or (3) a stipulation that is approved by a Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board.

(m) "Permanent partial disability award" means a final award of permanent partial disability determined by a workers' compensation administrative law judge or the appeals board.

(n) "Regular work" means the employee's usual occupation or the position in which the employee was engaged at the time of injury and that offers wages and compensation equivalent to those paid to the employee at the time of injury, and located within a reasonable commuting distance of the employee's residence at the time of injury.

(o) "Seasonal work" means employment as a daily hire, a project hire, or an annual season hire.

(p) "Supplemental job displacement benefit" means an educational retraining or skills enhancement allowance for injured employees whose employers are unable to provide work consistent with the requirements of Labor Code section 4658.6.

(q) "Vocational & return to work counselor (VRTWC)" means a person or entity capable of assisting a person with a disability with development of a return to work strategy and whose regular duties involve the evaluation, counseling and placement of disabled persons. A VRTWC must have at least an undergraduate degree in any field and three or more years full time experience in conducting vocational evaluations, counseling and placement of disabled adults.

(r) "Work restrictions means permanent medical limitations on employment activity established by the treating physician, qualified medical examiner or agreed medical examiner.

Note: Authority cited: Sections 133, 139.48, 4658.5 and 5307.3, Labor Code. Reference: Sections 124, 139.48, 4658.1, 4658.5 and 4658.6, Labor Code; and Henry v. WCAB (1998) 68 Cal.App.4th 981.

HISTORY

1. Renumbering of former section 10001 to new section 10116.9, including amendment of section heading, section and Note, filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No.47).

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ARTICLE 6.5. RETURN TO WORK

New query

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§10117. Offer of Work; Adjustment of Permanent Disability Payments.

(a) This section shall apply to all injuries occurring on or after January 1, 2005, and to the following employers:
(1) Insured employers who employed 50 or more employees at the time of the most recent policy inception or renewal date for the insurance policy that was in effect at the time of the employee's injury;

(2) Self-insured employers who employed 50 or more employees at the time of the most recent filing by the employer of the Self-Insurer's Annual Report that was in effect at the time of the employee's injury; and

(3) Legally uninsured employers who employed 50 or more employees at the time of injury.

(b) Within 60 calendar days from the date that the condition of an injured employee with permanent partial disability becomes permanent and stationary:

(1) If an employer does not serve the employee with a notice of offer of regular work, modified work or alternative work for a period of at least 12 months, each payment of permanent partial disability remaining to be paid to the employee from the date of the end of the 60 day period shall be paid in accordance with Labor Code section 4658(d)(1) and increased by 15 percent.

(2) If an employer serves the employee with a notice of offer of regular work, modified work or alternative work for a period of at least 12 months, and in accordance with the requirements set forth in paragraphs (3) and (4), each payment of permanent partial disability remaining to be paid from the date the offer was served on the employee shall be paid in accordance with Labor Code section 4658(d)(1) and decreased by 15 percent, regardless of whether the employee accepts or rejects the offer.

(3) The employer shall use form DWC-AD 10133.53 (Section 10133.53) to offer modified or alternative work, or form DWC-AD 10118 (Section 10118) to offer regular work. The claims administrator may serve the offer of work on behalf of the employer.

(4) The regular, alternative, or modified work that is offered by the employer pursuant to paragraph (2) shall be located within a reasonable commuting distance of the employee's residence at the time of the injury, unless the

employee waives this condition. This condition shall be deemed to be waived if the employee accepts the regular, modified, or alternative work, and does not object to the location within 20 calendar days of being informed of the right to object. The condition shall be conclusively deemed to be satisfied if the offered work is at the same location and the same shift as the employment at the time of injury.

(c) If the claims administrator relies upon a permanent and stationary date contained in a medical report prepared by the employee's treating physician, QME, or AME, but there is subsequently a dispute as to an employee's permanent and stationary status, and there has been a notice of offer of work served on the employee in accordance with subdivision (b), the claims administrator may withhold 15% from each payment of permanent partial disability remaining to be paid from the date the notice of offer was served on the employee until there has been a final judicial determination of the date that the employee is permanent and stationary pursuant to Labor Code section 4062.

(1) Where there is a final judicial determination that the employee is permanent and stationary on a date later than the date relied on by the employer in making its offer of work, the employee shall be reimbursed any amount withheld up to the date a new notice of offer of work is served on the employee pursuant to subdivision (b).

(2) Where there is a final judicial determination that the employee is not permanent and stationary, the employee shall be reimbursed any amount withheld up to the date of the determination.

(3) The claims administrator is not required to reimburse permanent partial disability benefit payments that have been withheld pursuant to this subdivision during any period for which the employee is entitled to temporary disability benefit payments.

(d) If the employee's regular work, modified work, or alternative work that has been offered by the employer pursuant to paragraph (1) of subdivision (b) and has been accepted by the employee, is terminated prior to the end of the period for which permanent partial disability benefits are due, the amount of each remaining permanent partial disability payment from the date of the termination shall be paid in accordance with Labor Code section 4658 (d) (1), as though no decrease in payments had been imposed, and increased by 15 percent. An employee who voluntarily terminates his or her regular work, modified work, or alternative work shall not be eligible for the 15 percent increase in permanent partial disability payments pursuant to this subdivision.

(e) Nothing in this section shall prevent the parties from settling or agreeing to commute the permanent disability benefits to which an employee may be entitled. However, if the permanent disability benefits are commuted by a workers' compensation administrative law judge or the appeals board pursuant to Labor Code section 5100, the commuted sum shall account for any adjustment that would have been required by this section if payment had been made pursuant to Labor Code section 4658.

(f) When the employer offers regular, modified or alternative work to the employee that meets the conditions of this section and subsequently learns that the employee cannot lawfully perform regular, modified or alternative work, the employer is not required to provide the regular, modified or alternative work.

(g) If the employer offers regular, modified, or alternative seasonal work to the employee, the offer shall meet the following requirements:

(1) the employee was hired for seasonal work prior to injury;

(2) the offer of regular, modified or alternative seasonal work is of reasonably similar hours and working conditions to the employee's previous employment, and the one year requirement may be satisfied by cumulative periods of seasonal work;

(3) the work must commence within 12 months of the date of the offer; and

(4) The offer meets the conditions set forth in this section.

Note: Authority cited: Sections 133, 139.48 and 5307.3, Labor Code. Reference: Sections 139.48 and 4658, Labor Code; Del Taco v. WCAB (2000) 79 Cal.App.4th 1437; Anzelde v. WCAB (1996) 61 Cal. Comp. Cases 1458 (writ denied); and Henry v. WCAB (1998) 68 Cal.App.4th 981.

HISTORY

1. New article 6.5 (sections 10117-10120) and renumbering of former section 10002 to new section 10117, including amendment of section, filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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ARTICLE 6.5. RETURN TO WORK

New query

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§10118. Form [DWC AD 10118 Notice of Offer of Work].

Note: Authority cited: Sections 133, 139.48 and 5307.3, Labor Code. Reference: Sections 139.48 and 4658, Labor Code.

HISTORY

1. Renumbering of former section 10003 to new section 10118, including amendment of section heading and repealer and new form, filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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New query

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§10119. Return to Work Program.

(a) This section shall apply to injuries occurring on or after July 1, 2004;

(b) An "Eligible Employer" means any employer, except the state or an employer eligible to secure the payment of compensation pursuant to subdivision (c) of Section 3700, who, based on the employer's payroll records or other equivalent documentation or evidence, employed 50 or fewer full-time employees on the date of injury.

(c) "Full-time employee" means an employee who, during the period of his or her employment within the year preceding the injury, worked an average of 32 or more hours per week.

(d) The Return to Work Program is administered by the administrative director for the purpose of promoting the employee's early and sustained return to work following a work-related injury or illness.

(e) This program shall be funded by the Return to Work Fund, which shall consist of all penalties collected pursuant to Labor Code section 5814.6 and transfers made to this fund by the administrative director from the Workers' Compensation Administrative Revolving Fund established pursuant to Labor Code section 62.5. The reimbursements offered to eligible employees as set forth in this section shall be available only to the extent funds are available.

(f) An eligible employer shall be entitled to reimbursement through this program for expenses incurred to make workplace modifications to accommodate an employee's return to modified or alternative work, up to the following maximum amounts:

(1) $1,250 to accommodate each temporarily disabled employee, for expenses incurred in allowing such employee to perform modified or alternative work within physician-imposed temporary work restrictions; and

(2) $2,500 to accommodate each permanently disabled employee, for expenses incurred in returning such employee to sustained modified or alternative work within physician-imposed permanent work restrictions; however, if an employer who has received reimbursement for a temporarily disabled employee under paragraph (1) is also requesting reimbursement for the same employee for accommodation of permanent disability, the maximum available reimbursement is $2,500. For the purpose of this subdivision, "sustained modified or alternative work" is work anticipated to last at least 12 months.

(g) Reimbursement shall be provided for any of the following expenses, provided they are specifically prescribed by a

physician or are reasonably required by restrictions set forth in a medical report:

(1) modification to worksite;

(2) equipment;

(3) furniture;

(4) tools; or

(5) any other necessary costs reasonably required to accommodate the employee's restrictions.

(h) An eligible employer seeking reimbursement pursuant to subdivision (d) shall submit a "Request for Reimbursement of Accommodation Expenses" (Form DWC AD 10120, section 10120) to the Division of Workers' Compensation Return to Work Program within ninety (90) calendar days from the date of the expenditure for which the employer is seeking reimbursement. As a condition to reimbursement, the expenditure shall not have been paid or covered by the employer's insurer or any source of funding other than the employer. The filing date may be extended upon a showing of good cause for such extension. The employer shall attach to its request copies of all pertinent medical reports that contain the work restrictions being accommodated, any other documentation supporting the request, and all receipts for accommodation expenses. Requests should be sent to the mailing address for the Division of Workers' Compensation Return to Work Program that is listed in the web site of the Division of Workers' Compensation, at: http://www.dir.ca.gov/dwc/dwc_home_page.htm

(i) The administrative director or his or her designee shall review each "Request for Reimbursement of Accommodation Expenses," and within sixty (60) business days of receipt shall provide the employer with notice of one of the following:

(1) that the request has been approved, together with a check for the reimbursement allowed, and an explanation of the allowance, if less than the maximum amounts set forth in subdivision (d); or

(2) that the request has been denied, with an explanation of the basis for denial; or

(3) that the request is deficient or incomplete and indicating what clarification or additional information is necessary.

(j) In the event there are insufficient funds in the Return to Work Fund to fully reimburse an employer or employers for workplace modification expenses as required by this section, the administrative director shall utilize the following priority list in establishing the amount of reimbursement or whether reimbursement is allowed, in order of decreasing priority as follows:

(1) Employers who have not previously received any reimbursement under this program;

(2) Employers who have not previously received any reimbursement under this program for the employee who is the subject of the request;

(3) Employers who are seeking reimbursement for accommodation required in returning a permanently disabled

employee to sustained modified or alternative work; and,

(4) Employers who are requesting reimbursement for accommodation required by a temporarily disabled employee.

(k) An eligible employer may appeal the administrative director's notice under subdivision (i) by filing a declaration of readiness to proceed within twenty calendar days of the issuance of the notice, together with a petition entitled "Petition Appealing Administrative Director's Reimbursement Allowance," setting forth the basis of the appeal pursuant to section 10294 of title 8 of the California Code of Regulations.

Note: Authority cited: Sections 133, 139.48 and 5307.3, Labor Code. Reference: Sections 62.5, 139.48 and 5814.6, Labor Code.

HISTORY

1. Renumbering of former section 10004 to new section 10119, including amendment of section, filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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ARTICLE 6.5. RETURN TO WORK

New query

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§10120. Form [DWC AD 10120 Request for Reimbursement of Accommodation Expenses].

Note: Authority cited: Sections 133, 139.48 and 5307.3, Labor Code. Reference: Sections 62.5, 139.48 and 5814.6, Labor Code.

HISTORY

1. Renumbering of former section 10005 to new section 10120, including amendment of section heading and repealer and new form, filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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New query

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§10122. Definitions. (Repealed)

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 124, 139.5, 4635 and 4644, Labor Code.

HISTORY

1. New section filed 1-18-90; operative 1-18-90 (Register 90, No. 4). New section is exempt from review by OAL pursuant to Government Code section11351.

2. Change without regulatory effect amending section filed 1-22-91 pursuant to section 100, title 1, California Code of Regulations (Register 91, No. 10).

3. Amendment filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

4. Amendment of subsections (d), (e), (g) and (l), new subsections (m) and (n), and amendment of Note filed 8-26-98; operative 9-25-98 (Register 98, No.35).

5. Amendment alphabetizing definitions and relettering subsections filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

6. Change without regulatory effect repealing subsection (b) and relettering subsections filed 5-1-2003 pursuant to section 100, title 1, California Codeof Regulations (Register 2003, No. 18).

7. Change without regulatory effect repealing article 7 (sections 10122-10133.. 22) and section filed 2-25-2009 pursuant to section 100, title 1, CaliforniaCode of Regulations (Register 2009, No. 9).

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§10122.1. Weekend or Holiday Deadlines. (Repealed)

Note: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Sections 133, 139.5 and 4637, Labor Code.

HISTORY

1. New section filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

2. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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§10123. Vocational Rehabilitation Reporting Requirements. [Repealed]

Note: Authority cited: Sections 133, 139.5, 4658, 4658.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code;Godinez v. Buffets, Inc. (2004, Significant Panel Decision) 69 Cal. Comp. Cases 1311; andVulean Materials Co. v. WCAB (2006, Writ Denied) 71 Cal. Comp. Cases 1346.

HISTORY

1. New section filed 1-18-90; operative 1-18-90 (Register 90, No. 4). New section is exempt from review by OAL pursuant to Government Code Section11351.

2. Change without regulatory effect amending section filed 1-22-91 pursuant to section 100, title 1, California Code of Regulations (Register 91, No. 10).

3. Amendment of subsections (a)(2), (c)(2), (d), (e), (e)(1) and (f), repealer of subsections (f)(1)-(g)(2) and subsection relettering, and amendment of newly designated subsections (g)-(i) filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

4. Change without regulatory effect amending subsection (f) and Note filed 3-14-94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 11).

5. Amendment of subsection (g) filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 8).

6. Amendment of section heading, section and Note, filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

7. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9)

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§10123.1. Reproduction of Forms, Notices. [Renumbered]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 139.5, 4636, 4637, 4638 and 4645, Labor Code.

HISTORY

1. Change without regulatory effect adding new section filed 1-22-91 pursuant to section 100, title 1, California Code of Regulations (Register 91, No. 10).

2. Editorial correction of printing error restoring section 10123.2 (Register 91, No. 31).

3. Renumbering and amendment of former section 10123.2 to section 10123.1 filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

4. Amendment filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 8).

5. Amendment of first paragraph filed 8-7-95; operative 8-7-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 32).

6. Amendment of first paragraph filed 9-11-95; operative 9-11-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 37).

7. Renumbering of former section 10123.1 to section 10116.4 filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§10123.2.Unrepresented Employees. [Repealed]

Note: Authority cited: Sections 133, 139.5, 139.6 and 5307.3, Labor Code. Reference: Sections 139.5, 4636, 4637, 4638 and 4645, Labor Code.

HISTORY

1. Change without regulatory effect adding new section filed 1-22-91 pursuant to section 100, title 1, California Code of Regulations (Register 91, No. 10).

2. Editorial correction of printing error restoring section 10123.1 (Register 91, No. 31).

3. Renumbering of former section 10123.1 to section 10123.2 filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

4. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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New query

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§10123.3. Referral to Rehabilitation Providers; Facilities. (Repealed)

Note: Authority cited: Sections 133, 139.5, 139.6 and 5307.3, Labor Code. Reference: Section 139.5(h), Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

2. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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New query

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§10124. Identification of Medical Eligibility. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 139.5 and 4636, Labor Code.

HISTORY

1. Change without regulatory effect renumbering and amending former section 10124 to section 10127.1 and former section 10124.1 to section 10124 filed 1-22-91 pursuant to section 100, title 1, California Code of Regulations (Register 91, No. 10). For prior history, see Register 90, No. 4.

2. Editorial correction of printing error restoring section 10124 (Register 91, No. 31).

3. Amendment of section heading and section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

4. Change without regulatory effect amending subsection (b) filed 3-14-94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 11).

5. Amendment of subsections (b)-(b)(1) filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 8).

6. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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New query

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§10124.1.Identification of Vocational Feasibility. (Repealed)

Note: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Sections 4635 and 4637, Labor Code.

HISTORY

1. New section filed 5-30-2001; operative 6-29-2001 (Register 2001, No. 22). For prior history, see Register 91, No. 46.

2. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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§10125.Maximum Vocational Rehabilitation Expenditures for Injuries Occurring On or After 1/1/94. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 139.5, 4636, 4638 and 4642, Labor Code.

HISTORY

1. Renumbering of former section 10125 to section 10127.2 and new section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

2. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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§10125.1. Vocational Rehabilitation Maintenance Allowance. (Repealed)

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 139.5, 4636, 4638 and 4642, Labor Code

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

2. Change without regulatory effect amending subsection (a) filed 3-14-94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 11).

3. Amendment of subsection (c) filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 8).

4. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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New query

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§10125.2. Vocational Rehabilitation Additional Living Expenses. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 139.5 and 4641, Labor Code.

HISTORY

1. New section filed 8-26-98; operative 9-25-98 (Register 98, No. 35).

2. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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New query

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§10125.3. Entitlement to Vocational Rehabilitation Temporary Disability or Vocational Rehabilitation Maintenance Allowance. [Repealed]

Note: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Sections 139.5, 4642 and 4644, Labor Code.

HISTORY

1. New section filed 8-26-98; operative 9-25-98 (Register 98, No. 35).

2. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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§10126. Vocational Rehabilitation; Plans and Offers of Modified or Alternative Work. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 139.5, 4638 and 4644, Labor Code.

HISTORY

1. New section filed 1-18-90; operative 1-18-90 (Register 90, No. 4). New section is exempt from review by OAL pursuant to Government Code section 11351.

2. Change without regulatory effect amending section filed 1-22-91 pursuant to section 100, title 1, California Code of Regulations (Register 91, No. 10).

3. Amendment of section heading and section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

4. Change without regulatory effect amending subsections (c)(c) and (c) filed 3-14-94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 11).

5. Amendment of section heading, amendment of subsections (a)(2), (b)(1) and (h), new subsection (i), subsection relettering, amendment of newly designated subsections (j) and (k) and new subsection (l) filed 8-26-98; operative 9-25-98 (Register 98, No. 35).

6. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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§10127. Dispute Resolution. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code;Godinez v. Buffets, Inc. (2004, Significant Panel Decision) 69 Cal. Comp. Cases 1311; andVulean Materials Co. v. WCAB (2006, Writ Denied) 71 Cal. Comp. Cases 1346.

HISTORY

1. New section filed 1-18-90; operative 1-18-90 (Register 90, No. 4). New section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect amending section filed 1-22-91 pursuant to section 100, title 1, California Code of Regulations (Register 91, No. 10).

3. Amendment of first paragraph and subsection (a), new subsection (b) and subsection relettering, and amendment of newly designated subsection (c), (d) and (e) filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

4. Amendment of subsections (d)(2)-(e), new subsection (f) and amendment of Note filed 8-26-98; operative 9-25-98 (Register 98, No. 35).

6. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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§10127.1.

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code;Godinez v. Buffets, Inc. (2004, Significant Panel Decision) 69 Cal. Comp. Cases 1311; andVulean Materials Co. v. WCAB (2006, Writ Denied) 71 Cal. Comp. Cases 1346.

HISTORY

1. Change without regulatory effect renumbering and amending former section 10124 to section 10127.1 filed 1-22-91 pursuant to section 100, title 1, California Code of Regulations (Register 91, No. 10). For prior history see Register 90, No. 4.

2. Amendment of subsection (c) and Note filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

3. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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§10127.2. Independent Vocational Evaluator. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 4635 and 4639, Labor Code.

HISTORY

1. New section filed 1-18-90; operative 1-18-90 (Register 90, No. 4). New section is exempt from review by OAL pursuant to Government Code section 11351.

2. Change without regulatory effect amending section filed 1-22-91 pursuant to section 100, title 1, California Code of Regulations (Register 91, No. 10).

3. Renumbering of former section 10125 to section 10127.2 and amendment of subsections (d)-(f)(1) filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

4. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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New query

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§10127.3. Qualified Rehabilitation Representative (QRR). [Repealed]

HISTORY

1. New section filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

2. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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§10128. Request for Order of Rehabilitation Services. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code;Godinez v. Buffets, Inc. (2004, Significant Panel Decision) 69 Cal. Comp. Cases 1311; andVulean Materials Co. v. WCAB (2006, Writ Denied) 71 Cal. Comp. Cases 1346.

HISTORY

1. Change without regulatory effect renumbering and amending former section 10128 to section 10131.1 and former section 10130 to section 10128 filed 1-22-91; operative 1-22-91 (Register 91, No. 10). For prior history, see Register 90, No. 4.

2. Amendment filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53). \

3. Amendment of section and Note filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

4. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009,
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§10129. Interruption/Deferral of Services for Injuries Occurring Prior to 1/1/94. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 139.5 and 4644, Labor Code.

HISTORY

1. Change without regulatory effect renumbering and amending former section 10129 to section 10132 and former section 10131 to section 10129 filed 1-22-91; operative 1-22-91 (Register 91, No. 10). For prior history, see Register 90, No. 4.

2. Amendment of section heading, subsections (a)-(c), new subsection (d) filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

3. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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§10129.1.Interruption/Deferral of Services for Injuries Occurring on or After 1/1/94. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 139.5 and 4644, Labor Code.

HISTORY

1. New section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

2. New subsection (c) filed 2-25-99; operative 2-25-99 pursuant to Government Code section 11343.3(d) (Register 99, No. 9). (Register 93, No. 53).

3. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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New query

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§10130. Request for Reinstatement of Vocational Rehabilitation Services. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Section 4644, Labor Code.

HISTORY

1. Change without regulatory effect renumbering and amending former section 10130 to section 10128 and former section 10132 to section 10130 filed 1-22-91; operative 1-22-91 (Register 91, No. 10). For prior history, see Register 90, No. 4.

2. Amendment filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

3. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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New query

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§10131. Termination of Vocational Rehabilitation Services. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 139.5, 4644 and 4646, Labor Code.

HISTORY

1. Change without regulatory effect renumbering and amending former section 10131 to section 10129 and former section 10133 to section 10131 filed 1-22-91; operative 1-22-91 (Register 91, No. 10). For prior history, see Register 90, No. 4.

2. Amendment of section heading and section filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

3. Amendment filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

4. Amendment of subsection (a), new subsections (d)-(f) and amendment of NOTE filed 3-25-2003; operative 3-25-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 13).

5. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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New query

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§10131.1.Declination of Rehabilitation. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Section 4641 and 4644, Labor Code.

HISTORY

1. Change without regulatory effect renumbering and amending former section 10128 to section 10131.1 filed 1-22-91 pursuant to section 100, title 1, California Code of Regulations (Register 91, No. 10).

2. Amendment filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

3. Change without regulatory effect amending subsection (b)(2) filed 3-14-94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 11).

4. Amendment filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

5. Amendment of subsection (d) filed 8-26-98; operative 9-25-98 (Register 98, No. 35).

6. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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New query

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§10131.2. Settlement of Prospective Vocational Rehabilitation. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 139.5, 4644 and 4646, Labor Code.

HISTORY

1. New section filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5). For prior history, see Register 96, No. 13.

2. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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New query

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§10132. Fee Schedule. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 4635, 4636, 4638 and 4639, Labor Code.

HISTORY

1. Change without regulatory effect renumbering and amending former section 10132 to section 10130 and new section 10132 filed 1-22-91; operative 1-22-91 (Register 91, No. 10). For prior history, see Register 90, No. 4.

2. Amendment filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

3. New subsection (c) and subsection relettering filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section11351 (Register 95, No. 8).

4. Amendment of subsections (a)-(c), new subsection (d), subsection relettering and amendment of newly designated subsection (f) filed 8-26-98; operative 9-25-98 (Register 98, No. 35).

5. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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§10132.1. Reasonable Fee Schedule. (Repealed)

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 4635, 4636, 4638 and 4639, Labor Code

HISTORY

1. Change without regulatory effect adding new section filed 1-22-91; operative 1-22-91 (Register 91, No. 10). For prior history, see Register 90, No. 4.

2. Amendment filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

3. Amendment filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 8).

4. Amendment of fee schedule filed 3-26-96; operative 3-26-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 13).

5. Amendment filed 7-16-98; effective 9-24-98 (Register 97, No. 38Z).

6. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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New query

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§10133.Forms, Form Filing Instructions & Notices. (Repealed)

Note: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Sections 139.5, 4635, 4636, 4637, 4638, 4641, 4644 and 4646, Labor Code.

HISTORY

1. Change without regulatory effect renumbering and amending former section 10133 to section 10131 and new section 10133 filed 1-22-91; operative 1-22-91 (Register 91, No. 10). For prior history, see Register 90, No. 4.

2. New Form RU-94, repealer and new Forms RU-102, RU-105 and RU-107, and repealer of Forms RU-104, RU-105-W, RU-500-W.1, RU-500-X, RU-500-Y and RU-500-Z filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

3. Amendment of forms RU-91 and RU-103 filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 8).

4. Amendment of Forms RU-102 and RU-105 filed 8-26-98; operative 9-25-98 (Register 98, No. 35).

5. Repealer and new forms RU-94 and RU-103 filed 2-25-99; operative 2-25-99 pursuant to Government Code section 11343.3(d) (Register 99, No. 9).

6. Relocation of Forms RU-90, RU-91, RU-94, RU-102, RU-103, RU-105 and RU-107A to sections 10133.10, 10133.11, 10133.12, 10133.13, 10133.14, 10133.16 and 10133.19 filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

7. Amendment of section heading, new section text, and amendment of NOTE filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 13.)

8. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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§10133.1. Standardized Report Forms

NOTE

Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code..

HISTORY

1. New section filed 2-16-95; operative 2-16-95. Submitted to OAL for printing only pursuant to Government Code §11351 (Register 95, No. 7).

2. Amendment of subsections (a) and (b) and relocation and amendment of forms RU-120 and RU-121 from section 10133.3 to section 10133.1 filed 8-26-98; operative 9-25-98 (Register 98, No. 35).

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§10133.2. Pamphlets. (Repealed)

HISTORY

1. New section filed 2-21-95; operative 2-21-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 8).

2. Amendment of section and Note filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

3. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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§10133.3. Rehabilitation Unit File Retention. [Repealed].

Note: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code..

HISTORY

1. Renumbering and amendment of former section 10019 to section 10134 filed 2-16-95; operative 2-16-95. Submitted to OAL for printing only pursuant to Government Code § 11351 (Register 95, No. 7).

2. Amendment of section number filed 8-8-95; operative 8-8-95. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 95, No. 32).

3. Amendment of subsection (a) and and relocation of forms RU-120 and RU-121 from section 10133.3 to section 10133.1 filed 8-26-98; operative 9-25-98 (Register 98, No. 35).

4. Repealer filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10133.4.Rehabilitation of Industrially Injured Inmates. (Repealed)

Note: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Sections 3351 and 3370, Labor Code; and Section 5069, Penal Code.

HISTORY

1. Renumbering of former section 10021 to new section 10133.4 and amendment of section and Note filed 12-27-96; operative 12-27-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 52).

2. Change without regulatory effect repealing section filed 2-25-2009 pursuant to section 100, title 1, California Code of Regulations (Register 2009, No. 9).

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§10133.10. Form RU-90 "Treating Physician's Report of Disability Status" and Form Filing Instructions. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 4636 and 4637, Labor Code.

HISTORY

1. New section, relocation of Form RU-90 from section 10133 to section 10133.10, and new form filing instructions filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

2. Change without regulatory effect repealing section (Form RU-90 and form filing instructions) filed 2-25-2009 pursuant to section 100, title 1,California Code of Regulations (Register 2009, No. 9).

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New query

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§10133.11. Form RU-91 "Description of Employee's Job Duties" and Form Filing Instructions. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 4636 and 4637, Labor Code.

HISTORY

1. New section, relocation and amendment of Form RU-91 from section 10133 to section 10133.11, and new form filing instructions filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

2. Change without regulatory effect repealing section (Form RU-91 and form filing instructions) filed 2-25-2009 pursuant to section 100, title 1,California Code of Regulations (Register 2009, No. 9).

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§10133.12. Form RU-94 “Notice of Offer of Modified or Alternative Work" and Form Filing Instructions. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 4636 and 4637, Labor Code.

HISTORY

1. New section, relocation and amendment of Form RU-94 from section 10133 to section 10133.12, and new form filing instructions filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

2. Change without regulatory effect repealing section (Form RU-94 and form filing instructions) filed 2-25-2009 pursuant to section 100, title 1,California Code of Regulations (Register 2009, No. 9).

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§10133.13. Form RU-102 “Vocational Rehabilitation Plan” and Form Filing Instructions. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code;Godinez v. Buffets, Inc. (2004, Significant Panel Decision) 69 Cal. Comp. Cases 1311; andVulean Materials Co. v. WCAB (2006, Writ Denied) 71 Cal. Comp. Cases 1346. HISTORY

1. New section, relocation and amendment of Form RU-102 from section 10133 to section 10133.13, and new form filing instructions filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No.5).

2. Repealer and new form and amendment of Note filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No.47).

3. Change without regulatory effect repealing section (Form RU-102 and form filing instructions) filed 2-25-2009 pursuant to section 100, title 1,California Code of Regulations (Register 2009, No. 9

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§ 10133.14. Form RU-103 “Request for Dispute Resolution” and Form Filing Instructions. (Repealed)

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code;Godinez v. Buffets, Inc. (2004, Significant Panel Decision) 69 Cal. Comp. Cases 1311; andVulean Materials Co. v. WCAB (2006, Writ Denied) 71 Cal. Comp. Cases 1346.

HISTORY

1. New section, relocation and amendment of Form RU-103 from section 10133 to section 10133.14, and new form filing instructions filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No.5).

2. Repealer and new form and amendment of Note filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No.47).

3. Change without regulatory effect repealing section (Form RU-103 and form filing instructions) filed 2-25-2009 pursuant to section 100, title 1,California Code of Regulations (Register 2009, No. 9).

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§ 10133.15. Form RB-105 “Request for Conclusion of Rehabilitation Benefits” and Form Filing Instructions. [Repealed]

Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 4637, 4643 and 4644, Labor Code.

HISTORY

1. New section and new Form RB-105 and form filing instructions filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

2. Change without regulatory effect repealing Form RB-105 and adopting new Form RB-105 filed 5-1-2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 18).

3. Editorial correction replacing erroneously printed form RU-105 with correct form RB-105 (Register 2008, No. 47).

4. Change without regulatory effect repealing section (Form RB-105 and form filing instructions) filed 2-25-2009 pursuant to section 100, title 1,California Code of Regulations (Register 2009, No. 9).

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§10133.16. Form RU-105 “Notice of Termination of Vocational Rehabilitation Services” and Form Filing Instructions. Repealed

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Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code;Godinez v. Buffets, Inc. (2004, Significant Panel Decision) 69 Cal. Comp. Cases 1311; andVulean Materials Co. v. WCAB (2006, Writ Denied) 71 Cal. Comp. Cases 1346.

HISTORY

1. New section, relocation and amendment of Form RU-105 from section 10133 to section 10133.16, and new form filing instructions filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No.5).

2. Change without regulatory effect repealing Form RU-105 and adopting new Form RU-105 filed 5-1-2003 pursuant to section 100, title 1, California Code ofRegulations (Register 2003, No. 18).

3. Repealer and new form and amendment of Note filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

4. Change without regulatory effect repealing section (Form RU-105 and form filing instructions) filed 2-25-2009 pursuant to section 100, title 1,California Code of Regulations (Register 2009, No. 9).

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§10133.16. Form RU-105 "Notice of Termination of Vocational Rehabilitation Services" and Form Filing Instructions. Repealed

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Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code;Godinez v. Buffets, Inc. (2004, Significant Panel Decision) 69 Cal. Comp. Cases 1311; andVulean Materials Co. v. WCAB (2006, Writ Denied) 71 Cal. Comp. Cases 1346.

HISTORY

1. New section, relocation and amendment of Form RU-105 from section 10133 to section 10133.16, and new form filing instructions filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

2. Change without regulatory effect repealing Form RU-105 and adopting new Form RU-105 filed 5-1-2003 pursuant to section 100, title 1, California Code ofRegulations (Register 2003, No. 18).

3. Repealer and new form and amendment of Note filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

4. Change without regulatory effect repealing section (Form RU-105 and form filing instructions) filed 2-25-2009 pursuant to section 100, title 1,California Code of Regulations (Register 2009, No. 9).

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§10133.18. Form RU-107 “Employee Statement of Declination of Vocational Rehabilitation Services” and Form Filing Instructions. Repealed

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Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 4641 and 4644, Labor Code.

HISTORY

1. New section and new Form RU-107 and form filing instructions filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

2. Change without regulatory effect repealing section (Form RU-107 and form filing instructions) filed 2-25-2009 pursuant to section 100, title 1,California Code of Regulations (Register 2009, No. 9).

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§10133.19. Form RU-107A "Statement of Declination of Vocational Rehabilitation Services" and Form Filing Instructions. Repealed

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Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Sections 4641 and 4644, Labor Code.

HISTORY

1. New section, relocation and amendment of Form RU-107-A from section 10133 to section 10133.19, and new form filing instructions filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

2. Change without regulatory effect repealing section (Form RU-107A and form filing instructions) filed 2-25-2009 pursuant to section 100, title 1,California Code of Regulations (Register 2009, No. 9).

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§10133.20. Form RU-120 "Initial Evaluation Summary" and Form Filing Instructions. Repealed

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Note: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code.

HISTORY

1. New section, relocation and amendment of Form RU-120 from section 10133 to section 10133.20, and new form filing instructions filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

2. Change without regulatory effect repealing section (Form RU-120 and form filing instructions) filed 2-25-2009 pursuant to section 100, title 1,California Code of Regulations (Register 2009, No. 9).

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§10133.19. Form RU-107A "Statement of Declination of Vocational Rehabilitation Services" and Form Filing Instructions. Repealed

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Note: Authority cited: Sections 133, 138.4, 139.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code.

HISTORY

1. New section, relocation and amendment of Form RU-107-A from section 10133 to section 10133.19, and new form filing instructions filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

2. Change without regulatory effect repealing section (Form RU-121 and form filing instructions) filed 2-25-2009 pursuant to section 100, title 1,California Code of Regulations (Register 2009, No. 9).

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§10133.22. Form RU-122 “Settlement of Prospective Vocational Rehabilitation Services” and Form Filing Instructions. Repealed

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Note: Authority cited: Sections 133, 139.5 and 5307.3, Labor Code. Reference: Section 139.5, Labor Code;Godinez v. Buffets, Inc. (2004, Significant Panel Decision) 69 Cal. Comp. Cases 1311; andVulean Materials Co. v. WCAB (2006, Writ Denied) 71 Cal. Comp. Cases 1346.

HISTORY

1. New section and new Form RU-122 and form filing instructions filed 1-29-2003; operative 1-29-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 5).

2. Repealer and new form and amendment of Note filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

3. Change without regulatory effect repealing section (Form RU-122 and form filing instructions) filed 2-25-2009 pursuant to section 100, title 1,California Code of Regulations (Register 2009, No. 9).

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§10133.50. Definitions. [Repealed]

Note: Authority cited: Sections 133, 4658.5 and 5307.3, Labor Code. Reference: Sections 124, 4658.1, 4658.5 and 4658.6, Labor Code.

HISTORY

1. New article 7.5 (sections 10133.50-10133.60) and section filed 6-6-2005; operative 8-1-2005 (Register 2005, No. 23).

2. Repealer filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10133.51. Notice of Potential Right to Supplemental Job Displacement Benefit.

(a) This section and section 10133.52 shall only apply to injuries occurring on or after January 1, 2004.

(b) Within 10 days of the last payment of temporary disability, if not previously provided, the claims administrator shall send the employee, by certified mail, the mandatory form “Notice of Potential Right to Supplemental Job Displacement Benefit Form” that is set forth in Section 10133.52.

NOTE

Authority cited: Sections 133, 4658.5 and 5307.3, Labor Code. Reference: Section 4658.5, Labor Code.

HISTORY

1. New section filed 6-6-2005; operative 8-1-2005 (Register 2005, No. 23)

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§10133.52. "Notice of Potential Right to Supplemental Job Displacement Benefit Form."

Notice of Potential Right to Supplemental Job Displacement Benefit Form
(Mandatory Form)

If your injury causes permanent partial disability, which prevented you from returning to work within 60 days of the last payment of temporary disability, and the claims administrator has not provided you with a Form DWC-AD 10133.53 "Notice of Offer of Modified or Alternative Work," you may be eligible for a supplemental job displacement benefit in the form of a nontransferable voucher for education-related retraining or skill enhancement, or both, at state approved or accredited schools.

The amount of the voucher for the supplemental job displacement benefit will be as follows:

Up to four thousand dollars ($4,000) for a permanent partial disability award of less than 15%.

Up to six thousand dollars ($6,000) for a permanent partial disability award between 15 and 25%.

Up to eight thousand dollars ($8,000) for a permanent partial disability award between 26 and 49%.

Up to ten thousand dollars ($10,000) for a permanent partial disability award between 50 and 99%.

A permanent partial disability award is issued by a Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board. You may also settle your potential eligibility for a voucher as part of a compromise and release settlement for a lump sum payment. Any settlement must be reviewed and approved by a Workers' Compensation Administrative Law Judge.

The voucher may be used for payment of tuition, fees, books, and other expenses required by the school for retraining or skill enhancement. Not more than 10 percent of the voucher moneys may be used for vocational or return to work counseling. A list of vocational return to work counselors is available on the Division of Workers' Compensation's website www.dir.ca.gov or upon request.

If you are eligible, and you have not already settled the benefit, you will receive the voucher from the claims administrator within 25 calendar days from the date the permanent partial disability award is issued by the Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board.

If modified or alternative work is available, you will receive a Form DWC-AD 10133.53 "Notice of Offer of Modified or Alternative Work" from the claims administrator within 30 days of the termination of temporary disability indemnity

payments. The claims administrator will not be required to pay for supplemental job displacement benefits if the offer for modified or alternative work meets the following conditions:

(1) You have the ability to perform the essential functions of the job provided;

(2) the job provided is in a regular position lasting at least 12 months;

(3) the job provided offers wages and compensation that are at least 85 percent of those paid to you at the time of the injury; and

(4) the job is located within reasonable commuting distance of your residence at the time of injury.

If there is a dispute regarding the Supplemental Job Displacement Benefit, the employee or claims administrator may file Form DWC-AD 10133.55 "Request for Dispute Resolution before the Administrative Director."

If you have a question or need more information, you can contact your employer or the claims administrator listed below. You can also contact a State Division of Workers' Compensation Information and Assistance Officer.

Date: _____ Name of Claims Administrator: _____ _____Phone No.: _____ Address of Claims Administrator: _____ _____ _____ _____ Email (optional): _____ _____ _____ _____

Note: Authority cited: Sections 133, 4658.5 and 5307.3, Labor Code. Reference: Section 4658.5, Labor Code.

HISTORY

1. New section filed 6-6-2005; operative 8-1-2005 (Register 2005, No. 23). 8 CA ADC s 10133.52

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§10133.53. Form DWC-AD 10133.53 “Notice of Offer of Modified or Alternative Work."

Form DWC-AD 10133.53

Note: Authority cited: Sections 133, 4658 and 5307.3, Labor Code. Reference: Sections 4658, 4658.1, 4658.5 and 4658.6, Labor Code.

HISTORY

1. New section filed 6-6-2005; operative 8-1-2005 (Register 2005, No. 23).

2. Amendment filed 7-19-2006; operative 8-18-2006 (Register 2006, No. 29).
For prior history, see Register 96, No. 52.

3. Repealer and new form filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§10133.54. Dispute Resolution.

(a) This section and section 10133.55 shall only apply to injuries occurring on or after January 1, 2004.

(b) When there is a dispute regarding the Supplemental Job Displacement Benefit, the employee, or claims administrator may request the administrative director to resolve the dispute.

(c) The party requesting the administrative director to resolve the dispute shall:

(1) Complete Form DWC-AD 10133.55 "Request for Dispute Resolution before the Administrative Director;"

(2) Clearly state the issue(s) and identify supporting information for each issue and position;

(3) Attach all pertinent documents;

(4) Submit a copy of the request and all attached documents to the administrative director and serve a copy of the request and all attached documents on all parties; and

(5) Attach a signed and dated proof of service to the Form DWC-AD 10133.55 "Request for Dispute Resolution before the Administrative Director."

(d) The opposing party shall have twenty (20) calendar days from the date of the proof of service of the Request to submit the original response and all attached documents to the administrative director and serve a copy of the response and all attached documents on all parties.
(e) The administrative director or his or her designee may request additional information from the parties.

(f) The administrative director or his or her designee shall issue a written determination and order based solely on the request, response, and any attached documents within thirty (30) calendar days of the date the opposing party's response and supporting information is due. If the administrative director or his or her designee requests additional information, the written determination shall be issued within thirty (30) calendar days from the receipt of the additional information. In the event no decision is issued within sixty (60) calendar days of the date the opposing party's response

is due or within sixty (60) calendar days of the administrative director's receipt of the requested additional information, whichever is later, the request shall be deemed to be denied.

(g) Either party may appeal the determination and order of the administrative director by filing a written petition together with a declaration of readiness to proceed pursuant to section 10250 within twenty calendar days of the issuance of the decision or within twenty days after a request is deemed denied pursuant to subdivision (f). The petition shall set forth the specific factual and/or legal reason(s) for the appeal as set forth in section 10294.5 of title 8 of the California Code of Regulations.

Note: Authority cited: Sections 133, 4658.5 and 5307.3, Labor Code. Reference: Sections 4658.5 and 4658.6, Labor Code.

HISTORY

1. New section filed 6-6-2005; operative 8-1-2005 (Register 2005, No. 23).

2. Amendment filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10133.55. Form DWC-AD 10133.55 "Request for Dispute Resolution Before the Administrative Director."

Form DWC-AD 10133.55

Note: Authority cited: Sections 133, 4658.5 and 5307.3, Labor Code. Reference: Section 4658.5, Labor Code.

HISTORY

1. New section filed 6-6-2005; operative 8-1-2005 (Register 2005, No. 23).

2. Amendment filed 7-19-2006; operative 8-18-2006 (Register 2006, No. 29).
For prior history, see Register 96, No. 52.

3. Repealer and new form filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§10133.56. Requirement to Issue Supplemental Job Displacement Nontransferable Training Voucher.

(a) This section and section 10133.57 shall only apply to injuries occurring on or after January 1, 2004.

(b) The employee shall be eligible for the Supplemental Job Displacement Benefit when:

(1) the injury causes permanent partial disability; and

(2) within 30 days of the termination of temporary disability indemnity payments, the claims administrator does not offer modified or alternative work in accordance with Labor Code section 4658.6; and

(3) either the injured employee does not return to work for the employer within 60 days of the termination of temporary disability benefits; or

(4) in the case of a seasonal employee, where the employee is unable to return to work within 60 days of the termination of temporary disability benefits because the work season has ended, the injured employee does not return to work on the next available work date of the next work season.

(c) When the requirements under subdivision (b) have been met, the claims administrator shall provide a nontransferable voucher for education-related retraining or skill enhancement or both to the employee within 25 calendar days from the issuance of the permanent partial disability award by the workers' compensation administrative law judge or the appeals board.

(d) The voucher shall be issued to the employee allowing direct reimbursement to the employee upon the employee's presentation to the claims administrator of documentation and receipts or as a direct payment to the provider of the education related training or skill enhancement and/or to the VRTWC.

(e) The voucher must indicate the appropriate level of money available to the employee in compliance with Labor Code section 4658.5.

(f) The mandatory voucher form is set forth in Section 10133.57.

(g) The voucher shall certify that the school is approved by one of the Regional Associations of Schools and Colleges

authorized by the United States Department of Education or has approval from a California State agency that has an agreement with the United States Department of Education or Regional Associations of School and Colleges for the regulation and oversight of non-degree granting private post secondary providers.

(h) The claims administrator shall issue the reimbursement payments to the employee or direct payments to the VRTWC and the training providers within 45 calendar days from receipt of the completed voucher, receipts and documentation.

Note: Authority cited: Sections 133, 4658.5, 4658.6 and 5307.3, Labor Code. Reference: Sections 4658.5 and 4658.6, Labor Code.

HISTORY

1. New section filed 6-6-2005; operative 8-1-2005 (Register 2005, No. 23).

2. Amendment of subsections (c) and (g) filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§10133.57. Form DWC-AD 10133.57 "Supplemental Job Displacement Nontransferable Training Voucher Form."

Form DWC-AD 10133.57

Note: Authority cited: Sections 133, 4658.5 and 5307.3, Labor Code. Reference: Section 4658.5, Labor Code.

HISTORY

1. New section filed 6-6-2005; operative 8-1-2005 (Register 2005, No. 23).

2. Repealer and new form filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§10133.58. State Approved or Accredited Schools.

(a) This section shall only apply to injuries occurring on or after January 1, 2004.

(b) Private providers of education-related retraining or skill enhancement selected to provide training as part of a supplemental job displacement benefit shall be:

(1) accredited by one of the Regional Associations of Schools and Colleges authorized by the United States Department of Education; or

(2) has approval from a California State agency that has an agreement with the United States Department of Education or Regional Associations of School and Colleges for the regulation and oversight of non-degree granting private post secondary providers; or

(3) certified by the Federal Aviation Administration.

Note: Authority cited: Sections 133, 4658.5 and 5307.3, Labor Code. Reference: Section 4658.5, Labor Code.

HISTORY

1. New section filed 6-6-2005; operative 8-1-2005 (Register 2005, No. 23).

2. Amendment filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10133.59. The Administrative Director's List of Vocational Return to Work Counselors.

(a) This section shall only apply to injuries occurring on or after January 1, 2004.

(b) The Administrative Director shall maintain a list of Vocational & Return to Work Counselors (VRTWC) who perform the work of assisting injured employees. A VRTWC who meets the qualifications specified in Section 10133.50(a)(15) must apply to the Administrative Director to be included on the list throughout the year. The list shall be reviewed and revised on a yearly basis, and shall be made available on the website www.dir.ca.gov or upon request.

(c) The injured employee may select a Vocational & Return to Work Counselor whenever the assistance of a Vocational & Return to Work Counselor is needed to facilitate an employee's vocational training or return to work in connection with the Supplemental Job Displacement Benefit set forth in this Article.

(d) The injured employee shall be responsible for providing the VRTWC with any necessary medical reports. However, a claims administrator shall provide a VRTWC with any medical reports, including permanent and stationary medical reports, upon an employee's written request and a signed release waiver.

(e) The VRTWC shall communicate with the injured employee regarding the evaluation.

NOTE

Authority cited: Sections 133, 4658.5 and 5307.3, Labor Code. Reference: Section 4658.5, Labor Code.

HISTORY

1. New section filed 6-6-2005; operative 8-1-2005 (Register 2005, No. 23)

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§10133.60. Termination of Claims Administrator's Liability for the Supplemental Job Displacement Benefit.

(a) For injuries occurring on or after January 1, 2004, the claims administrator's liability to provide a supplemental job displacement voucher shall end if either (a)(1) or (a)(2) occur:

(1) the claims administrator offers modified or alternative work to the employee, meeting the requirements of Labor Code §4658.6, on DWC-AD Form 10133.53 “Notice of Offer of Modified or Alternative Work”;

(A) If the claims administrator offers modified or alternative work to the employee for 12 months of seasonal work, the offer shall meet the following requirements:

1. the employee was hired on a seasonal basis prior to injury; and

2. the offer of modified or alternative work is on a similar seasonal basis to the employee's previous employment;

(2) the maximum funds of the voucher have been exhausted.

NOTE

Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4658.1, 4658.5, 4658.6 and 5410, Labor Code; and Henry v. WCAB (1998) 68 Cal.App.4th 981.

HISTORY

1. New section filed 6-6-2005; operative 8-1-2005 (Register 2005, No. 23)

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 8. Attorney Fee Disclosure Statement

New query

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§10134. Attorney Fee Disclosure Statement Form.

DWC Form 3, Attorney Fee Disclosure Statement Form. (.pdf format, 5K)

NOTE: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Section 4906(e), Labor Code.

HISTORY

1. New section filed 1-18-90; operative 1-18-90 (Register 90, No. 4). New section is exempt from review by OAL pursuant to Government Code section 11351.

2. Repealer and new section filed 4-13-93; operative 4-13-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 16)

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 8. Attorney Fee Disclosure Statement

New query

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§10135. Required Use of Form.

Every attorney or his/her agent who consults with an injured worker or dependent is required to furnish the attorney fee disclosure statement form set forth in Section 10134 of this Article to the injured worker or dependent at the initial consultation.

NOTE: Authority cited: Section 133 and 5307.3, Labor Code. Reference: Section 4906(e), Labor Code.

HISTORY

1. New section filed 1-18-90; operative 1-18-90 (Register 90, No. 4). New section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Amendment filed 4-13-93; operative 4-13-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 16)

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1.5. Injuries on or After January 1, 1990
Article 8. Attorney Fee Disclosure Statement

New query

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§10135.1. Service of Form.

Within 15 days of the employee's and attorney's execution of the disclosure form, a copy of the disclosure form shall be mailed to the employer or, if known, to the employer's insurer or third-party administrator.

NOTE: Authority cited: Section 133 and 5307.3, Labor Code. Reference: Section 4906(e), Labor Code.

HISTORY

1. New section filed 4-13-93; operative 4-13-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 16).

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SUBCHAPTER 1.5. INJURIES ON OR AFTER JANUARY 1, 1990
ARTICLE 9. CLAIM FORM: AVAILABILITY, FILING, ACKNOWLEDGEMENT OF RECEIPT, DISMISSAL

New query

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§10136. General: Definitions.

(a) Claims Administrator. A self-administered workers' compensation insurer, a self-administered self-insured employer, a self-administered joint powers authority, or a third-party claims administrator for an insurer, a self-insured employer, a legally-uninsured employer or a joint powers authority; or an attorney or agent of any of those entities. (b) Claim Form. The official Division of Workers' Compensation DWC Form 1 Employee's Claim for Workers' Compensation Benefits, as set forth in Section 10139 of this Article. (c) Employee. An employee, a person claiming to be an employee, his or her dependents, or agent.

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 5401, 5401.7, 5402 and 5404.5, Labor Code.

HISTORY

1. New section filed 1-18-90; operative 1-18-90 (Register 90, No. 4). New section is exempt from review by OAL pursuant to Government Code Section11351.

2. Amendment of subsections (b), (b)(3), (b)(4) and (c), repealer of subsections (b)(5), (d), (e) and (f), and new subsection (d) filed 4-13-93; operative 4-13-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 16)

3. Change without regulatory effect repealing article 9 heading, renumbering former article 6 to new article 9, renumbering former section 10136 to section 10252 and renumbering former section 10116 to section 10136, including amendment of subsection (b), filed 4-7-2008 pursuant to section 100, title1, California Code of Regulations (Register 2008, No. 15).

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New query

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§10137. General: Employer Obligation.

Nothing in this article shall abrogate the duty of an employer to provide timely compensation to an injured worker, even if the employee has not completed and filed the form required by Labor Code Section 5401 and this article.

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 5401 and 3200-6208, Labor Code.

HISTORY

1. New section filed 1-18-90; operative 1-18-90 (Register 90, No. 4). New section is exempt from review by OAL pursuant to Government Code Section11351.

2. Repealer and new section filed 4-13-93; operative 4-13-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 16)

3. Change without regulatory effect renumbering former section 10137 to section 10252.1 and renumbering former section 10116.1 to section 10137 filed 4-7-2008 pursuant to section 100, title 1, California Code of Regulations (Register 2008, No. 15).

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Chapter 4.5. Division of Workers' Compensation
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Article 9. CLAIM FORM: AVAILABILITY, FILING, ACKNOWLEDGEMENT OF RECEIPT, DISMISSAL

New query

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§ 10138. Claim Form and Notice of Potential Eligibility for Benefits.

The employee's form for filing a workers' compensation claim (DWC 1) and the Notice of Potential Eligibility for Benefits is a mandatory form set forth in Section 10139 of this Article. The employer portion of the form may also include other information pertinent to the claim, including a logo or other employer-identifying information, but such information shall in no way impose additional duties or prohibitions on the employee or delay the processing of the claim. The claim form consists of an original and three (3) copies.

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 5401, 5401.7 and 5402, Labor Code.

HISTORY

1. Change without regulatory effect renumbering former section 10117.1 to section 10138, including amendment of section, filed 4-7-2008 pursuant to section 100, title 1, California Code of Regulations (Register 2008, No.15).

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New query

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§ 10139. Workers' Compensation Claim Form (DWC 1) and Notice of Potential Eligibility.

Claim form (DWC 1)

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 132(a), 139.48, 139.6, 4600, 4600.3, 4601, 4604.5, 4616, 4650, 4656, 4658.5, 4658.6, 4700, 4701, 4702, 4703, 5400, 5401, 5401.7 and 5402, Labor Code.

HISTORY

1. Change without regulatory effect renumbering former section 10118.1 to section 10139 filed 4-7-2008 pursuant to section 100, title 1, California Code of Regulations (Register 2008, No. 15).

2. Amendment of section and Note filed 8-9-2010; operative 10-8-2010 (Register 2010, No. 33).

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ARTICLE 9. CLAIM FORM: AVAILABILITY, FILING, ACKNOWLEDGEMENT OF RECEIPT, DISMISSAL

New query

§10140. Employer's Responsibility to Process Claim Form, Claims Administrator's Duty to Provide Claim Form.

(a) Within one working day of receipt of a claim form, the employer shall date the claim form and provide a dated copy of the form to the employee and the employer's claims administrator.

(b) If the claims administrator obtains knowledge that the employer has not provided a claim form, it shall provide one to the employee within three working days of its knowledge that the form was not provided.

(c) If the claims administrator cannot determine if the employer has provided a claim form to the employee, the claims administrator shall provide one to the employee within 30 days of the administrator's date of knowledge of the claim.

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 5401 and 5402, Labor Code.

HISTORY

1. Change without regulatory effect renumbering former section 10119 to section 10140 filed 4-7-2008 pursuant to section 100, title 1, California Code ofRegulations (Register 2008, No. 15).

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Chapter 4.5. Division of Workers' Compensation
SUBCHAPTER 1.5. INJURIES ON OR AFTER JANUARY 1, 1990
ARTICLE 9. CLAIM FORM: AVAILABILITY, FILING, ACKNOWLEDGEMENT OF RECEIPT, DISMISSAL

New query

§ 10140. Employer's Responsibility to Process Claim Form, Claims Administrator's Duty to Provide Claim Form.

(a) Within one working day of receipt of a claim form, the employer shall date the claim form and provide a dated copy of the form to the employee and the employer's claims administrator.

(b) If the claims administrator obtains knowledge that the employer has not provided a claim form, it shall provide one to the employee within three working days of its knowledge that the form was not provided.

(c) If the claims administrator cannot determine if the employer has provided a claim form to the employee, the claims administrator shall provide one to the employee within 30 days of the administrator's date of knowledge of the claim.

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 5401 and 5402, Labor Code.

HISTORY

1. Change without regulatory effect renumbering former section 10119 to section 10140 filed 4-7-2008 pursuant to section 100, title 1, California Code ofRegulations (Register 2008, No. 15).

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New query

10142. Date of Denial for Purposes of End of Tolling of Limitations Period.

For purposes of Labor Code Section 5401(c), the date "the claim is denied" for determining when the claim form ceases to toll the specified limitations periods is:

(a) the date the written denial notice is personally served, or

(b) five days after the written denial notice is placed in the mail if the address is within the State of California, ten days if the address is outside the State of California, but within the United States and twenty days if the address is outside of the United States.

The written denial notice must be issued in accordance with the notice regulations in Title 8, CCR, Subchapter 1, Article 8, Sections 9810 et seq. in order to cease the claim form's tolling of the limitations periods.
Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Section 5401, Labor Code.

HISTORY

1. Change without regulatory effect renumbering former section 10121 to section 10142 filed 4-7-2008 pursuant to section 100, title 1, California Code ofRegulations (Register 2008, No. 15).

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STATE OF CALIFORNIA
Department of Industrial Relations
Division of Workers' Compensation
DISABILITY EVALUATION UNIT

NOTICE OF OPTIONS FOLLOWING DISABILITY RATING

This is a disability rating determination (Rating) prepared by the State of California Disability Evaluation Unit within the Division of Workers' Compensation. It describes your percentage of disability. This percentage is based on your limitations as reported by the doctor, your potential loss of future earning capacity, your age, and the type of work you were doing at the time of your injury. If the rating indicates that you have some permanent disability, you should automatically begin to receive permanent disability payments. Payments are made in installments, every two weeks, for the number of weeks shown on the rating, less any permanent disability payments made to you prior to the rating.

If the rating is not disputed by you or your employer, you do not have to take any action to receive your benefits. We do want you to know that you may have two options you may want to consider. They are:

1) STIPULATED FINDINGS AND AWARD;
2) COMPROMISE AND RELEASE;

1) STIPULATED FINDINGS AND AWARD

If you and the employer, carrier or agent, accept the rating, written agreements may be submitted to the Workers' Compensation Appeals Board (WCAB) requesting that an Award be made without the need for a hearing. We recommend this option when the rating is not disputed, and you have a need for future medical care. A Workers' Compensation Judge will review the stipulations and issue an award.

ADVANTAGES

- A stipulated award is a quick, easy way to settle your case while protecting your rights;
- There is no need to take time off work to go to a hearing;
- The Division of Workers' Compensation will review the settlement to protect your rights at no cost to you; there is no need to hire a lawyer;
- If your condition worsens, you can apply for additional payments anytime within five years from the date of your injury;
- If you need additional medical care or you are to receive a life pension (rating of 70% or more), your rights to future benefits can be fully protected and a judge can enforce the award if there later becomes a problem.
- You may request a lump sum payment of all or part of your permanent disability if you can show a financial need or hardship. However, a Workers' Compensation Judge must first be convinced that it would be in your best interest.

DISADVANTAGES

- You normally will not receive a lump sum payment, but will receive your benefits in payments every two weeks.

2) COMPROMISE AND RELEASE

A Compromise and Release Agreement is a settlement which usually permanently closes all aspects of a workers' compensation claim except for vocational rehabilitation benefits, including any provision for future medical care.

The Compromise and Release is paid in one lump sum to you. It must be reviewed and approved by a Workers' Compensation Judge.

ADVANTAGES

- You may receive more money than you would receive under a Stipulated Findings and Award because you are giving up your future rights in exchange for money.
- If the employer or insurance company disputes the rating, a Compromise and Release will assure you receive an agreed amount of money now rather than risk getting nothing or a lesser amount later.
- You will receive your benefits in one lump sum.

DISADVANTAGES

- A Compromise and Release usually permanently releases the employer from all future responsibilities. After your case has been resolved by a Compromise and Release Agreement, you cannot ask for more medical treatment at your employer's expense, nor can you claim additional benefits if your disability or condition becomes worse. Also, if you later die as a result of the injury, your dependents would not be entitled to death benefits.
- Once a Workers' Compensation Judge has approved your Compromise and Release, the settlement is final and it cannot be set aside except in very rare circumstances.

If you would like more information, you can receive recorded information free of charge, by calling 1-800-736-7401 or you may contact your local Information and Assistance officer (listed in the state government section of your telephone book under Department of Industrial Relations, Division of Workers' Compensation). You may also consult an attorney of your choice.

SPECIAL NOTICE TO UNREPRESENTED INJURED WORKERS

If you disagree with the rating because you believe that the rating was improperly calculated or that the doctor failed to address any or all issues or failed to properly rate your impairment, you may request administrative review of the rating within 30 days of receipt of the rating, from the Administrative Director of the Division of Workers' Compensation. In some cases, you may be entitled to an additional medical evaluation or a different medical specialist. Your request should include a copy of the rating and a copy of the report from the doctor. A copy of the request must be sent to your claims adjustor.

If you have questions about whether to request administrative review of your rating or whether another medical evaluation is appropriate, you should contact the local Information and Assistance Officer listed in the state government section of your telephone book under Department of Industrial Relations, Division of Workers' Compensation. They can tell you how to file the request if you decide to do so.

COMMUTATION INSTRUCTIONS

The following examples illustrate various methods of commuting permanent disability and life pension benefits. Examples A, B and C apply to permanent disability and utilize Table 1, "Present Value of Fixed Annuity at 3% Interest". Examples D, E and F apply to life pension and utilize Tables 2 and 3 (for males and females respectively), "Present Value of Lifetime Annuity at 3% Interest..."

EXAMPLE A: COMMUTATION OF ALL REMAINING PD

In this example, all PD due for the period after the date of commutation is commuted.

Assumed facts for Example A:

Date of injury: 4/10/96
PD commencement date: 2/20/98
Date of commutation (DOC): 5/14/99

PD rating: 65%
Weekly PD rate: $164
Number of weeks of indemnity corresponding to 65% PD: 386.25

1) Determine weeks of PD remaining after date of commutation (DOC).

a)	#days from PD commencement through DOC inclusive.....	449
b)	Divide by 7 days/week.....	÷ 7
c)	#weeks from PD commencement through DOC.....	64.1429
d)	Total weeks of PD	386.2500
e)	Subtract weeks elapsed through DOC (from 1c).....	− 64.1429
f)	Weeks of PD remaining after date of commutation.....	322.1071

2) Determine PV of weeks of PD remaining after DOC (1f).

a)	PV of #weeks just above 1f* (PV of 323 wks).....	295.0041
b)	Subtract next lower PV from table* (PV of 322 wks).....	−294.1718
c)	Difference of 2a and 2b.....	.8323
d)	Multiply by fractional portion of 1f.....	× .1071
e)	PV of fractional week.....	.0891
f)	Add 2b	+ 294.1718
g)	PV of weeks remaining after DOC.....	294.2609

* Values for 2a and 2b taken from PV column of Table 1.

(continued on next page)

(Example A continued)

3) Determine commuted value of all PD due for period after DOC.

a)	PV of weeks remaining after DOC (from 2g).....	294.2609
b)	Multiply by PD rate.....	× 164
c)	Commuted value of all PD due for period after DOC.....	$48,258.79

Summary of Example A:

- On date of commutation (DOC), $48,258.79 would be due and payable. This is the commuted value of all remaining PD. If payment is made at a later date, interest at 10% per annum is due for the period from DOC to date of actual payment. For example, if the payment in this instance is made on 5/26/99, i.e. twelve days after the date of commutation, interest of $158.66 would be due calculated as follows: 48,258.79 X 12 X .1 ÷ 365*.

  * The formula for calculation of interest is:
  (Commuted value) X (#Days between DOC and payment date) X .1 ÷ 365

EXAMPLE B: COMMUTATION OF PD "OFF THE FAR END" TO PRODUCE A SPECIFIC LUMP SUM

In this example, sufficient monies are to be commuted off the far end of the PD award to produce a payment on the date of commutation of $11,500. All facts are identical to those used in Example A. The calculation of the number of weeks of PD remaining after DOC used in this example is illustrated in step 1 of Example A. The calculation of the PV of weeks remaining after DOC used in this example is illustrated in step 2 of Example A.

Assumed facts:

Date of injury: 4/10/96
PD commencement date: 2/20/98
Date of commutation (DOC): 5/14/99

PD rating: 65%
Weekly PD rate: $164
Number of weeks of indemnity corresponding to 65% PD: 386.25

Weeks of PD remaining after DOC (1f from Example A): 322.1071
PV of weeks remaining after DOC (2g from Example A): 294.2609

1) Determine PV (at $1/week) of amount to be commuted.

a)	Amount to be commuted.....	11,500
b)	Divide by weekly PD rate.....	÷ 164
c)	PV of amount to be commuted.....	70.1220

(continued on next page)

(Example B continued)

2) Determine PV of weeks remaining after commutation off far end.

a)	PV of weeks remaining after DOC (2g from Ex. A).....	294.2609
b)	Subtract PV of amount to be commuted (1c from above).....	− 70.1220
c)	PV of weeks remaining after commutation off far end.....	224.1389

3) Determine number of weeks of PD remaining after commutation off far end.

a)	PV just above 2c* (corresponding to 240 wks PD).....	224.2725
b)	Subtract PV just below 2c* (corresp. to 239 wks PD).....	− 223.3996
c)	Difference of 3a and 3b (PV of 240th week).....	.8729

*Values for 3a and 3b taken from PV column of Table 1.

d)	PV of weeks remaining after commut. off far end (2c).....	224.1389
e)	Subtract 3b (PV of 239 weeks).....	− 223.3996
f)	Difference of 3d and 3e.....	.7393
g)	Divide by 3c (PV of 240th week).....	÷ .8729
h)	Proportional amount of 240th week.....	.8469
i)	Add to 239 weeks.....	+ 239.0000
j)	#weeks PD remaining after commutation off far end.....	239.8469

4) Determine amount of PD due after commutation off far end.

a)	#weeks PD remaining after commutation off far end (3j).....	239.8469
b)	Multiply by PD rate.....	× 164
c)	PD still owed for period after DOC.....	$39,334.89

5) Determine number of weeks of PD eliminated from the far end.

a)	# weeks PD before commut. off far end (1f from Ex. A).....	322.1071
b)	Subtract #weeks PD remaining after commut. (3j).....	− 239.8469
c)	#weeks PD eliminated from far end.....	82.2602

Summary of Example B:

- On date of commutation (DOC), $11,500 would be due and payable. If payment is made after the DOC, interest is due at 10% per annum. See Summary of Example A for interest calculation.
- Following the payment of $11,500, the claims administrator would still owe 239.8469 weeks of PD (3j) payable on a biweekly basis in the total amount of $39,334.89 (4c).
- The number of weeks of PD eliminated from the far end as a result of the commutation would be 82.2602 (5c).

(Continued on next page)

EXAMPLE C: COMMUTATION OF PD BY UNIFORM REDUCTION OF PAYMENTS

In this example, sufficient monies are commuted by uniform reduction of all future payments of PD to produce a payment on the date of commutation of $11,500. All facts from Example A apply here. The calculation of number of weeks of PD remaining after DOC used in this example is illustrated in step 1 of Example A. The calculation of PV of remaining weeks used in this example is illustrated in step 2 of Example A.

Assumed facts:

Date of injury: 4/10/96
PD commencement date: 2/20/98
Date of commutation (DOC): 5/14/99

PD rating: 65%
Weekly PD rate: $164
Number of weeks of indemnity corresponding to 65% PD: 386.25

Lump sum to be paid on DOC: $11,500
Number of weeks of PD remaining after DOC (1f from Example A): 322.1071
PV of weeks of PD remaining after DOC (2g from Ex. A): 294.2609

1) Determine amount of reduction required to produce lump sum

a)	Amount desired to be commuted.....	$11,500
b)	Divide by PV of remaining weeks (2g from Ex. A).....	÷ 294.2609
c)	Amount of reduction after rounding to nearest whole cent.....	$39.08

2) Determine new PD rate after reduction

a)	Weekly PD rate	164.00
b)	Subtract amount of reduction (1c).....	− 39.08
c)	New PD rate after reduction.....	$124.92

3) Determine amount of PD still owed for period after DOC

a)	#weeks of PD remaining after DOC (1f from Example A).....	322.1071
b)	Multiply by new PD rate after reduction (2c).....	× 124.92
c)	Amount of PD still owed for period after DOC.....	$40,237.62

Summary of Example C:

- On date of commutation (DOC), $11,500 would be due and payable. If payment is made after DOC, interest is due at 10% per annum. See Summary of Example A for interest calculation.
- As a result of the commutation, payments for the period following the DOC would be due at the reduced weekly rate of $124.92 (2c).
- Following the payment of $11,500, the balance of PD benefits owed would be 322.1071 weeks payable on a biweekly basis in the total amount of $40,237.62 (3c).

(Continued on next page)

EXAMPLE D - COMMUTATION OF ALL REMAINING LIFE PENSION AFTER LIFE PENSION HAS COMMENCED

In this example, the commutation occurs after the commencement of life pension. On the date of commutation, all life pension indemnity owed for the period thereafter is commuted.

Assumed facts for Example D:

Date of birth (DOB): 8/25/45
Date of injury: 4/10/87
Life pension commencement date: 3/21/98
Date of commutation: 5/14/99

Life pension rate: $33.92
Gender: male

1) Determine exact age on date of commutation.

a)	Number of days from DOB through DOC*.....	19620
b)	Divide by number of days per year.....	÷ 365.24
c)	Exact age on date of commutation.....	53.718

* Note that in determining exact age, the actual date of birth is not counted as the first day of the period. That is, an individual does not become one day old until the day after the DOB. This differs from the determination of the number of days for a period of benefits when the commencement date is counted as the first day of the period. See, for example, step 1a of Example A.

2) Determine PV of life pension as of exact age on DOC

a)	PV for age in table below 1c* (age 53).....	847.65
b)	PV for age in table above 1c (age 54)*.....	− 827.23
c)	Difference of 2a and 2b.....	20.42
d)	Multiply by fractional portion of age from 1c.....	× .718
e)	Interpolation adjustment for 2d.....	14.66
f)	PV for age in table below 1c* (from 2a above).....	847.65
g)	Subtract 2e	− 14.66
h)	PV of life pension as of exact age on DOC.....	832.99

* Value taken from column titled “Immed.” in Table 2.

3) Determine commuted value of all life pension indemnity due after DOC

a)	PV of life pension as of exact age on DOC (from 2h).....	832.99
b)	Multiply by life pension rate.....	× 33.92
c)	Commuted value of all life pension due after DOC	$28.255.02

(Continued on next page)

(Example D continued)

Summary of Example D:

- On date of commutation, $28,255.02, the commuted value of all life pension indemnity for the period after DOC, would be due and payable(3c). No further life pension indemnity would be due. If payment was made after DOC, interest would be due at 10% per annum. See Summary of Example A for interest calculation.

EXAMPLE E - COMMUTATION OF ALL LIFE PENSION INDEMNITY PRIOR TO COMMENCEMENT OF LIFE PENSION

In this example, the commutation of all life pension is done prior to commencement of life pension while the injured worker is still receiving PD. Calculation of exact age at DOC used in this example is illustrated in step 1 of Example†D.

Assumed facts for Example E:

Date of birth: 8/25/45
Date of injury: 4/10/96
PD commencement: 11/15/97
Date of commutation (DOC): 5/14/99

Total weeks of PD: 525.50 (based on 81% PD rating)
Life pension rate: $65.42
Gender: female
Exact age on DOC (from 1c of Example D): 53.718

1) Determine number of years between date of commutation (DOC) and commencement of life pension.

a)	Total weeks of PD.....	525.5
b)	Multiply by 7 days per week.....	× 7
c)	Total days of PD.....3678.5	
d)	Subtract #days from PD commence through DOC inclusive...	− 546.0
e)	Number of days from DOC to LP commencement.....	3132.5
f)	Divide by 365.24 days/year.....	÷ 365.24
g)	Period in years from DOC to start of LP*.....	8.577

* This is the period for which the commencement of LP is "deferred". It determines which columns are used in Tables 2 (for males) or 3 (for females). In this example, you would use columns entitled "Year 8" and "Year 9" in Table 3.

(Continued on next page)

2) Determine PV of life pension for exact age at date of commutation (53.718 years from 1c of Example D) and for exact deferral period (8.577 years from†2g above).

a)	PV for age 53 deferred 8 years (from Table 3).....	603.31
b)	Subtract PV for age 54 deferred 8 years (from Table 3).....	584.78
c)	Difference of 2a and 2b.....	18.53
d)	Multiply by fractional portion of age at DOC.....	× .718
e)	Interpolation adjustment for age.....	13.30
f)	PV for age 53 deferred 8 years (from Table 3).....	603.31
g)	Subtract PV for age 53 deferred 9 years (from Table 3).....	− 565.04
h)	Difference of 2f and 2g.....	38.27
i)	Multiply by fractional portion of deferral period (from 1g).....	× .577
j)	Interpolation adjustment for deferral period.....	22.08
k)	PV for age 53 deferred 8 years (from 2a).....	603.31
l)	Subtract sum of 2e and 2j.....	− 35.38
m)	PV of life pension (for age 53.718 deferred 8.577 years).....	567.93

3) Determine commuted value of all LP as of DOC

a)	PV of life pension (from 2m).....	567.93
b)	Multiply by LP rate.....	× 65.42
c)	Commuted value of all life pension.....	$37,153.98

Summary of Example E:

- On date of commutation (DOC), $37,153.98, the commuted value of all life pension indemnity (3c), would be due and payable. No life pension would be due thereafter. (This amount would not include the commuted value of any future PD indemnity. If payment were made after DOC, interest would be due at 10% per annum. See Summary of Example A for interest calculation. To commute future PD, use the method illustrated in Example A.)

(Continued on next page)

EXAMPLE F - COMMUTATION OF PORTION OF REMAINING LIFE PENSION (LP) AFTER LP COMMENCEMENT BY UNIFORM REDUCTION OF LIFE PENSION PAYMENTS

In this example, the commutation of a portion of life pension is done after LP commencement. Sufficient monies are commuted through uniform reduction of payments from remaining life pension to produce an amount payable on the date of commutation of $11,500.

Assumed facts for Example F:

Date of birth (DOB): 8/25/45
Date of injury: 4/10/87
Life pension commencement date: 3/21/98
Date of commutation (DOC): 5/14/99

Life pension rate: $33.92
Gender: female
Lump sum to be paid on DOC: $11,500

1) Determine exact age on date of commutation.

a)	Number of days from DOB through DOC*.....	19620
b)	Divide by number of days per year.....	÷ 365.24
c)	Exact age on date of commutation.....	53.718

* Note that in determining exact age, the actual date of birth is not counted as the first day of the period. That is, an individual does not become one day old until the day after the DOB. This differs from the determination of the number of days for a period of benefits when the commencement date is counted as the first day of the period. See, for example, step 1a of Example A.

2) Determine PV of life pension as of exact age on DOC

a)	PV for age in table below 1c* (age 53).....	966.59
b)	PV for age in table above 1c (age 54)*.....	− 947.30
c)	Difference of 2a and 2b.....	19.29
d)	Multiply by fractional portion of age from 1c.....	× .718
e)	Interpolation adjustment for 2d.....	13.85
f)	PV for age in table below 1c* (from 2a above).....	966.59
g)	Subtract 2e	− 13.85
h)	PV of life pension as of exact age on DOC.....	952.74

* Value taken from column titled “Immed.” in Table 3.

(Example F continued on next page)

3) Calculate amount of reduction in LP rate necessary to produce desired lump sum.

a)	Amount to be commuted.....	$11,500
b)	Divide by PV of LP (2h from above).....	÷ 952.74
c)	Amount of weekly reduction in LP (after rounding).....	$12.07

4) Calculate LP rate after commutation.

a)	LP rate before commutation.....	$33.92
b)	Subtract weekly reduction in LP (from 3c above).....	− $12.07
c)	LP rate after commutation.....	$21.85

Summary of Example F:

- On date of commutation, $11,500 would be due and payable. If payment were made after DOC, interest would be due at 10% per annum. See Summary of Example A for interest calculation.
- The life pension, when due, would be paid at the reduced rate of $21.85.

TABLE 1 - PRESENT VALUE OF PERMANENT DISABILITY

Use this table to commute, i.e. determine the present value of permanent disability benefits. The "Wks" column refers to the number of weeks of PD being commuted. The "PV" column contains the present value (PV) at $1 per week of the corresponding number of weeks of PD. A fractional number of weeks of PD may be commuted using interpolation. See Examples A, B and C under Commutation Procedures for an illustration of various types of commutations.

Wks	PV	Wks	PV	Wks	PV	Wks	PV
1	0.9989	45	44.4058	89	86.7442	133	128.0402
2	1.9977	46	45.3801	90	87.6945	134	128.9671
3	2.9955	47	46.3533	91	88.6437	135	129.8930
4	3.9932	48	47.3264	92	89.5929	136	130.8188
5	4.9898	49	48.2985	93	90.5410	137	131.7436
6	5.9864	50	49.2706	94	91.4892	138	132.6684
7	6.9819	51	50.2416	95	92.4362	139	133.5922
8	7.9774	52	51.2125	96	93.3833	140	134.5159
9	8.9717	53	52.1824	97	94.3293	141	135.4386
10	9.9661	54	53.1523	98	95.2753	142	136.3613
11	10.9593	55	54.1210	99	96.2202	143	137.2830
12	11.9525	56	55.0898	100	97.1651	144	138.2047
13	12.9446	57	56.0575	101	98.1090	145	139.1253
14	13.9367	58	57.0252	102	99.0529	146	140.0459
15	14.9277	59	57.9918	103	99.9956	147	140.9655
16	15.9187	60	58.9583	104	100.9384	148	141.8851
17	16.9085	61	59.9238	105	101.8801	149	142.8036
18	17.8984	62	60.8893	106	102.8219	150	143.7221
19	18.8871	63	61.8537	107	103.7625	151	144.6396
20	19.8759	64	62.8181	108	104.7032	152	145.5571
21	20.8635	65	63.7814	109	105.6428	153	146.4736
22	21.8511	66	64.7447	110	106.5823	154	147.3900
23	22.8376	67	65.7069	111	107.5209	155	148.3054
24	23.8241	68	66.6691	112	108.4594	156	149.2209
25	24.8095	69	67.6302	113	109.3968	157	150.1352
26	25.7948	70	68.5914	114	110.3343	158	151.0496
27	26.7791	71	69.5514	115	111.2707	159	151.9630
28	27.7634	72	70.5114	116	112.2071	160	152.8763
29	28.7465	73	71.4704	117	113.1424	161	153.7886
30	29.7297	74	72.4293	118	114.0778	162	154.7009
31	30.7117	75	73.3872	119	115.0121	163	155.6122
32	31.6937	76	74.3450	120	115.9463	164	156.5235
33	32.6747	77	75.3018	121	116.8796	165	157.4337
34	33.6556	78	76.2586	122	117.8128	166	158.3440
35	34.6354	79	77.2143	123	118.7449	167	159.2532
36	35.6152	80	78.1700	124	119.6771	168	160.1624
37	36.5939	81	79.1246	125	120.6082	169	161.0706
38	37.5726	82	80.0792	126	121.5393	170	161.9788
39	38.5502	83	81.0327	127	122.4694	171	162.8859
40	39.5278	84	81.9862	128	123.3994	172	163.7931
41	40.5043	85	82.9387	129	124.3284	173	164.6992
42	41.4808	86	83.8911	130	125.2574	174	165.6054
43	42.4562	87	84.8425	131	126.1854	175	166.5105
44	43.4315	88	85.7939	132	127.1133	176	167.4156

Wks	PV	Wks	PV	Wks	PV	Wks	PV
177	168.3197	231	216.4008	285	263.0333	339	308.2609
178	169.2237	232	217.2776	286	263.8837	340	309.0857
179	170.1268	233	218.1535	287	264.7332	341	309.9096
180	171.0298	234	219.0293	288	265.5827	342	310.7334
181	171.9319	235	219.9042	289	266.4312	343	311.5564
182	172.8339	236	220.7790	290	267.2797	344	312.3793
183	173.7349	237	221.6529	291	268.1272	345	313.2013
184	174.6359	238	222.5268	292	268.9747	346	314.0233
185	175.5359	239	223.3996	293	269.8213	347	314.8444
186	176.4359	240	224.2725	294	270.6679	348	315.6655
187	177.3349	241	225.1444	295	271.5135	349	316.4856
188	178.2339	242	226.0163	296	272.3591	350	317.3057
189	179.1318	243	226.8872	297	273.2038	351	318.1250
190	180.0298	244	227.7581	298	274.0485	352	318.9442
191	180.9267	245	228.6280	299	274.8922	353	319.7625
192	181.8236	246	229.4979	300	275.7359	354	320.5807
193	182.7196	247	230.3669	301	276.5786	355	321.3981
194	183.6155	248	231.2358	302	277.4214	356	322.2155
195	184.5104	249	232.1037	303	278.2632	357	323.0319
196	185.4053	250	232.9717	304	279.1050	358	323.8483
197	186.2992	251	233.8386	305	279.9458	359	324.6638
198	187.1931	252	234.7056	306	280.7866	360	325.4794
199	188.0860	253	235.5716	307	281.6265	361	326.2939
200	188.9789	254	236.4376	308	282.4664	362	327.1085
201	189.8707	255	237.3026	309	283.3054	363	327.9222
202	190.7626	256	238.1676	310	284.1443	364	328.7359
203	191.6535	257	239.0316	311	284.9823	365	329.5486
204	192.5443	258	239.8956	312	285.8203	366	330.3613
205	193.4342	259	240.7586	313	286.6573	367	331.1732
206	194.3240	260	241.6217	314	287.4944	368	331.9850
207	195.2129	261	242.4838	315	288.3305	369	332.7959
208	196.1017	262	243.3458	316	289.1665	370	333.6068
209	196.9896	263	244.2069	317	290.0017	371	334.4168
210	197.8774	264	245.0680	318	290.8368	372	335.2268
211	198.7642	265	245.9281	319	291.6710	373	336.0358
212	199.6511	266	246.7882	320	292.5052	374	336.8449
213	200.5369	267	247.6474	321	293.3385	375	337.6530
214	201.4227	268	248.5065	322	294.1718	376	338.4612
215	202.3075	269	249.3647	323	295.0041	377	339.2684
216	203.1924	270	250.2228	324	295.8364	378	340.0757
217	204.0762	271	251.0800	325	296.6677	379	340.8820
218	204.9600	272	251.9372	326	297.4991	380	341.6883
219	205.8428	273	252.7935	327	298.3295	381	342.4937
220	206.7257	274	253.6497	328	299.1600	382	343.2991
221	207.6075	275	254.5049	329	299.9895	383	344.1036
222	208.4893	276	255.3602	330	300.8190	384	344.9081
223	209.3701	277	256.2145	331	301.6475	385	345.7117
224	210.2510	278	257.0688	332	302.4760	386	346.5153
225	211.1308	279	257.9221	333	303.3037	387	347.3180
226	212.0106	280	258.7754	334	304.1313	388	348.1207
227	212.8894	281	259.6278	335	304.9579	389	348.9224
228	213.7683	282	260.4801	336	305.7846	390	349.7242
229	214.6461	283	261.3315	337	306.6104	391	350.5250
230	215.5239	284	262.1829	338	307.4361	392	351.3259

Wks	PV	Wks	PV	Wks	PV	Wks	PV
393	352.1259	447	394.6693	501	435.9309	555	475.9494
394	352.9258	448	395.4451	502	436.6834	556	476.6792
395	353.7249	449	396.2201	503	437.4350	557	477.4082
396	354.5239	450	396.9951	504	438.1866	558	478.1372
397	355.3220	451	397.7691	505	438.9374	559	478.8653
398	356.1202	452	398.5432	506	439.6882	560	479.5935
399	356.9174	453	399.3165	507	440.4381	561	480.3208
400	357.7147	454	400.0897	508	441.1880	562	481.0481
401	358.5110	455	400.8620	509	441.9371	563	481.7746
402	359.3073	456	401.6344	510	442.6862	564	482.5012
403	360.1028	457	402.4058	511	443.4344	565	483.2268
404	360.8982	458	403.1773	512	444.1826	566	483.9525
405	361.6927	459	403.9479	513	444.9300	567	484.6774
406	362.4873	460	404.7185	514	445.6774	568	485.4022
407	363.2809	461	405.4882	515	446.4239	569	486.1263
408	364.0745	462	406.2579	516	447.1704	570	486.8503
409	364.8673	463	407.0268	517	447.9161	571	487.5735
410	365.6600	464	407.7956	518	448.6618	572	488.2968
411	366.4518	465	408.5636	519	449.4067	573	489.0192
412	367.2437	466	409.3316	520	450.1515	574	489.7416
413	368.0346	467	410.0987	521	450.8955	575	490.4632
414	368.8256	468	410.8658	522	451.6395	576	491.1847
415	369.6156	469	411.6321	523	452.3827	577	491.9055
416	370.4056	470	412.3983	524	453.1258	578	492.6263
417	371.1948	471	413.1637	525	453.8681	579	493.3462
418	371.9839	472	413.9291	526	454.6104	580	494.0662
419	372.7722	473	414.6936	527	455.3519	581	494.7853
420	373.5605	474	415.4581	528	456.0934	582	495.5044
421	374.3478	475	416.2217	529	456.8340	583	496.2228
422	375.1352	476	416.9854	530	457.5747	584	496.9411
423	375.9217	477	417.7481	531	458.3145	585	497.6586
424	376.7081	478	418.5109	532	459.0543	586	498.3761
425	377.4937	479	419.2728	533	459.7932	587	499.0928
426	378.2793	480	420.0347	534	460.5322	588	499.8095
427	379.0640	481	420.7958	535	461.2703	589	500.5254
428	379.8487	482	421.5568	536	462.0084	590	501.2413
429	380.6325	483	422.3170	537	462.7457	591	501.9563
430	381.4163	484	423.0772	538	463.4830	592	502.6714
431	382.1992	485	423.8365	539	464.2194	593	503.3857
432	382.9821	486	424.5959	540	464.9559	594	504.0999
433	383.7641	487	425.3543	541	465.6915	595	504.8134
434	384.5462	488	426.1128	542	466.4271	596	505.5268
435	385.3273	489	426.8704	543	467.1619	597	506.2395
436	386.1085	490	427.6280	544	467.8967	598	506.9521
437	386.8887	491	428.3848	545	468.6306	599	507.6640
438	387.6690	492	429.1415	546	469.3646	600	508.3758
439	388.4484	493	429.8974	547	470.0977	601	509.0868
440	389.2277	494	430.6533	548	470.8308	602	509.7979
441	390.0062	495	431.4084	549	471.5631	603	510.5081
442	390.7847	496	432.1634	550	472.2954	604	511.2183
443	391.5623	497	432.9176	551	473.0269	605	511.9278
444	392.3399	498	433.6718	552	473.7583	606	512.6372
445	393.1167	499	434.4251	553	474.4890	607	513.3458
446	393.8934	500	435.1784	554	475.2196	608	514.0544

Wks	PV	Wks	PV	Wks	PV	Wks	PV
609	514.7622	663	552.4057	717	588.9151	771	624.3245
610	515.4701	664	553.0922	718	589.5809	772	624.9702
611	516.1771	665	553.7779	719	590.2459	773	625.6152
612	516.8841	666	554.4636	720	590.9110	774	626.2602
613	517.5903	667	555.1486	721	591.5753	775	626.9045
614	518.2965	668	555.8335	722	592.2396	776	627.5488
615	519.0019	669	556.5177	723	592.9031	777	628.1924
616	519.7074	670	557.2018	724	593.5667	778	628.8359
617	520.4120	671	557.8852	725	594.2295	779	629.4788
618	521.1166	672	558.5686	726	594.8923	780	630.1216
619	521.8204	673	559.2512	727	595.5543	781	630.7637
620	522.5242	674	559.9339	728	596.2164	782	631.4058
621	523.2273	675	560.6157	729	596.8777	783	632.0472
622	523.9303	676	561.2975	730	597.5390	784	632.6886
623	524.6325	677	561.9786	731	598.1995	785	633.3292
624	525.3347	678	562.6597	732	598.8601	786	633.9699
625	526.0362	679	563.3400	733	599.5199	787	634.6098
626	526.7376	680	564.0203	734	600.1797	788	635.2497
627	527.4382	681	564.6998	735	600.8388	789	635.8889
628	528.1389	682	565.3793	736	601.4978	790	636.5281
629	528.8387	683	566.0581	737	602.1561	791	637.1666
630	529.5386	684	566.7368	738	602.8144	792	637.8051
631	530.2376	685	567.4148	739	603.4720	793	638.4428
632	530.9367	686	568.0928	740	604.1296	794	639.0806
633	531.6349	687	568.7701	741	604.7864	795	639.7176
634	532.3332	688	569.4473	742	605.4432	796	640.3546
635	533.0306	689	570.1237	743	606.0993	797	640.9909
636	533.7281	690	570.8002	744	606.7553	798	641.6272
637	534.4248	691	571.4759	745	607.4107	799	642.2628
638	535.1215	692	572.1516	746	608.0660	800	642.8984
639	535.8174	693	572.8265	747	608.7206	801	643.5333
640	536.5133	694	573.5014	748	609.3752	802	644.1682
641	537.2084	695	574.1756	749	610.0290	803	644.8023
642	537.9035	696	574.8497	750	610.6829	804	645.4365
643	538.5978	697	575.5231	751	611.3360	805	646.0699
644	539.2921	698	576.1965	752	611.9891	806	646.7033
645	539.9856	699	576.8692	753	612.6415	807	647.3360
646	540.6792	700	577.5418	754	613.2938	808	647.9688
647	541.3719	701	578.2137	755	613.9455	809	648.6007
648	542.0646	702	578.8855	756	614.5971	810	649.2327
649	542.7566	703	579.5567	757	615.2480	811	649.8640
650	543.4486	704	580.2278	758	615.8989	812	650.4953
651	544.1397	705	580.8981	759	616.5490	813	651.1259
652	544.8309	706	581.5685	760	617.1992	814	651.7564
653	545.5213	707	582.2381	761	617.8486	815	652.3863
654	546.2117	708	582.9077	762	618.4980	816	653.0162
655	546.9013	709	583.5765	763	619.1467	817	653.6453
656	547.5909	710	584.2453	764	619.7954	818	654.2744
657	548.2797	711	584.9134	765	620.4434	819	654.9029
658	548.9686	712	585.5815	766	621.0913	820	655.5313
659	549.6566	713	586.2488	767	621.7385	821	656.1590
660	550.3447	714	586.9161	768	622.3857	822	656.7867
661	551.0320	715	587.5827	769	623.0322	823	657.4137
662	551.7192	716	588.2493	770	623.6787	824	658.0407

Wks	PV	Wks	PV	Wks	PV	Wks	PV
825	658.6670	879	691.9749	933	724.2793		
826	659.2933	880	692.5824	934	724.8685		
827	659.9189	881	693.1891	935	725.4569		
828	660.5445	882	693.7958	936	726.0454		
829	661.1694	883	694.4019	937	726.6332		
830	661.7943	884	695.0079	938	727.2210		
831	662.4184	885	695.6133	939	727.8081		
832	663.0426	886	696.2187	940	728.3952		
833	663.6661	887	696.8233	941	728.9817		
834	664.2895	888	697.4280	942	729.5681		
835	664.9123	889	698.0320	943	730.1539		
836	665.5350	890	698.6360	944	730.7397		
837	666.1571	891	699.2393	945	731.3249		
838	666.7791	892	699.8426	946	731.9100		
839	667.4005	893	700.4453	947	732.4945		
840	668.0218	894	701.0479	948	733.0789		
841	668.6425	895	701.6498	949	733.6628		
842	669.2631	896	702.2518	950	734.2466		
843	669.8831	897	702.8531				
844	670.5030	898	703.4543				
845	671.1222	899	704.0549				
846	671.7415	900	704.6555				
847	672.3600	901	705.2554				
848	672.9786	902	705.8553				
849	673.5964	903	706.4545				
850	674.2142	904	707.0537				
851	674.8314	905	707.6523				
852	675.4485	906	708.2508				
853	676.0650	907	708.8487				
854	676.6814	908	709.4466				
855	677.2971	909	710.0437				
856	677.9129	910	710.6409				
857	678.5279	911	711.2375				
858	679.1430	912	711.8340				
859	679.7573	913	712.4298				
860	680.3717	914	713.0256				
861	680.9853	915	713.6208				
862	681.5990	916	714.2160				
863	682.2119	917	714.8105				
864	682.8249	918	715.4050				
865	683.4371	919	715.9988				
866	684.0494	920	716.5926				
867	684.6610	921	717.1857				
868	685.2725	922	717.7789				
869	685.8834	923	718.3713				
870	686.4943	924	718.9638				
871	687.1045	925	719.5556				
872	687.7147	926	720.1474				
873	688.3242	927	720.7386				
874	688.9337	928	721.3297				
875	689.5425	929	721.9202				
876	690.1513	930	722.5106				
877	690.7594	931	723.1004				
878	691.3675	932	723.6902				

TABLE 2 - PRESENT VALUE OF LIFE PENSION FOR A MALE

Use this table to commute, i.e. determine the present value (PV) of life pension benefits for a male. The "Age on DOC" column refers to the age of the injured employee as of the date of the commutation. The columns labeled "0, 1, 2, 3. . ." refer to the period of years between the DOC and the commencement of life pension, commonly referred to as the "deferral period". The number at the intersection of the row (representing age) and column (representing deferral period) contains the present value at $1 per week for that combination of age and deferral period. Fractional ages and commencement delays can be accommodated using interpolation. See Examples D, E, and F under Commutation Procedures. This table is based on the U.S. Decennial Life Tables for 1989-91.

Age on DOC	Number of years between date of commutation (DOC) and commencement of life pension														
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
15	1401.79	1350.43	1300.62	1252.31	1205.48	1160.07	1116.06	1073.39	1032.04	991.95	953.10	915.45	878.96	843.60	809.32
16	1392.18	1340.83	1291.03	1242.75	1195.94	1150.56	1106.58	1063.94	1022.62	982.57	943.76	906.14	869.68	834.35	800.11
17	1382.60	1331.25	1281.46	1233.20	1186.41	1141.05	1097.09	1054.48	1013.18	973.16	934.37	896.77	860.34	825.04	790.83
18	1372.97	1321.63	1271.85	1223.59	1176.81	1131.47	1087.53	1044.94	1003.66	963.65	924.88	887.30	850.89	815.62	781.44
19	1363.21	1311.87	1262.09	1213.84	1167.08	1121.75	1077.82	1035.24	993.97	953.98	915.22	877.67	841.28	806.02	771.87
20	1353.22	1301.88	1252.11	1203.87	1157.11	1111.80	1067.88	1025.31	984.06	944.08	905.34	867.80	831.44	796.21	762.08
21	1343.02	1291.68	1241.91	1193.68	1146.93	1101.62	1057.71	1015.15	973.91	933.95	895.22	857.71	821.37	786.16	752.07
22	1332.57	1281.23	1231.47	1183.24	1136.50	1091.20	1047.29	1004.74	963.52	923.57	884.86	847.37	811.05	775.88	741.81
23	1321.88	1270.54	1220.78	1172.55	1125.81	1080.52	1036.62	994.08	952.87	912.94	874.25	836.78	800.49	765.35	731.31
24	1310.88	1259.54	1209.78	1161.56	1114.83	1069.53	1025.65	983.12	941.92	902.01	863.35	825.91	789.65	754.54	720.54
25	1299.58	1248.24	1198.48	1150.26	1103.53	1058.25	1014.37	971.86	930.68	890.80	852.16	814.75	778.52	743.44	709.49
26	1287.93	1236.59	1186.83	1138.62	1091.89	1046.62	1002.76	960.28	919.12	879.26	840.65	803.27	767.08	732.04	698.13
27	1275.93	1224.59	1174.84	1126.63	1079.92	1034.67	990.83	948.36	907.23	867.40	828.83	791.49	755.33	720.34	686.47
28	1263.61	1212.27	1162.53	1114.33	1067.63	1022.39	978.57	936.13	895.03	855.23	816.70	779.40	743.29	708.34	674.52
29	1250.98	1199.64	1149.91	1101.72	1055.04	1009.82	966.02	923.61	882.54	842.78	804.28	767.02	730.96	696.06	662.29
30	1238.06	1186.73	1137.00	1088.82	1042.16	996.96	953.19	910.80	869.77	830.04	791.58	754.37	718.35	683.50	649.78
31	1224.84	1173.51	1123.79	1075.63	1028.98	983.80	940.05	897.70	856.70	817.01	778.59	741.42	705.45	670.65	636.99
32	1211.32	1160.00	1110.28	1062.13	1015.50	970.34	926.62	884.30	843.33	803.68	765.31	728.18	692.25	657.51	623.92
33	1197.48	1146.16	1096.45	1048.31	1001.70	956.56	912.87	870.58	829.65	790.03	751.70	714.62	678.76	644.08	610.56
34	1183.31	1131.99	1082.29	1034.17	987.57	942.46	898.80	856.54	815.64	776.07	737.79	700.76	664.96	630.35	596.91
35	1168.82	1117.50	1067.81	1019.70	973.12	928.04	884.40	842.18	801.32	761.79	723.56	686.59	650.85	616.32	582.97
36	1153.99	1102.68	1052.99	1004.90	958.34	913.28	869.68	827.48	786.66	747.18	709.01	672.10	636.45	602.01	568.76
37	1138.83	1087.52	1037.85	989.77	943.23	898.19	854.62	812.46	771.68	732.25	694.14	657.32	621.75	587.41	554.28
38	1123.31	1072.01	1022.34	974.27	927.75	882.74	839.20	797.08	756.35	716.99	678.95	642.21	606.75	572.52	539.51
39	1107.41	1056.11	1006.45	958.40	911.90	866.91	823.40	781.33	740.67	701.38	663.42	626.78	591.43	557.33	524.46
40	1091.11	1039.80	990.16	942.12	895.64	850.69	807.23	765.21	724.62	685.41	647.56	611.03	575.80	541.84	509.13
41	1074.38	1023.09	973.45	925.43	878.98	834.07	790.66	748.72	708.20	669.09	631.35	594.94	559.86	526.06	493.53
42	1057.25	1005.95	956.33	908.33	861.92	817.06	773.72	731.85	691.43	652.43	614.81	578.55	543.63	510.01	477.69
43	1039.71	988.42	938.81	890.84	844.48	799.68	756.41	714.63	674.32	635.44	597.96	561.87	527.13	493.72	461.63
44	1021.80	970.52	920.93	873.00	826.69	781.95	738.77	697.09	656.90	618.16	580.84	544.93	510.40	477.22	445.37
45	1003.55	952.27	902.71	854.82	808.57	763.91	720.82	679.26	639.20	600.61	563.48	527.77	493.46	460.53	428.96
46	984.99	933.72	884.19	836.34	790.15	745.58	702.59	661.16	621.24	582.83	545.90	510.41	476.35	443.70	412.44
47	966.15	914.89	865.39	817.60	771.47	726.99	684.12	642.82	603.07	564.86	528.14	492.89	459.11	426.76	395.84
48	947.04	895.79	846.32	798.58	752.53	708.15	665.41	624.26	584.70	546.69	510.21	475.24	441.76	409.74	379.18
49	927.65	876.42	826.98	779.29	733.33	689.07	646.46	605.49	566.13	528.35	492.14	457.47	424.32	392.67	362.49
50	907.98	856.76	807.36	759.74	713.88	669.74	627.30	586.52	547.38	509.86	473.94	439.60	406.81	375.55	345.79

(Present Value of Life Pension for a Male - con't)

Age on DOC	Number of years between date of commutation (DOC) and commencement of life pension														
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
51	888.05	836.85	787.49	739.96	694.21	650.21	607.94	567.37	528.48	491.25	455.65	421.67	389.27	358.43	329.12
52	867.93	816.75	767.44	719.99	674.36	630.53	588.45	548.12	509.50	472.58	437.33	403.73	371.74	341.35	312.52
53	847.65	796.48	747.24	699.88	654.38	610.71	568.85	528.78	490.46	453.88	419.00	385.80	354.26	324.34	296.02
54	827.23	776.08	726.89	679.64	634.29	590.81	549.19	509.39	471.40	435.17	400.70	367.93	336.86	307.45	279.65
55	806.69	755.57	706.45	659.31	614.12	570.85	529.49	489.99	452.34	416.50	382.45	350.15	319.57	290.69	263.46
56	786.06	734.96	685.91	638.90	593.89	550.85	509.76	470.59	433.31	397.88	364.28	332.47	302.42	274.09	247.46
57	765.34	714.27	665.31	618.44	573.62	530.84	490.05	451.22	414.33	379.34	346.21	314.92	285.42	257.69	231.69
58	744.61	693.57	644.71	597.99	553.39	510.86	470.39	431.93	395.45	360.92	328.30	297.54	268.63	241.53	216.22
59	723.94	672.93	624.17	577.61	533.23	490.98	450.84	412.76	376.72	342.67	310.57	280.39	252.11	225.68	201.09
60	703.35	652.39	603.73	557.34	513.18	471.22	431.42	393.75	358.16	324.61	293.07	263.50	235.89	210.18	186.35
61	682.82	631.89	583.34	537.12	493.20	451.55	412.12	374.87	339.75	306.74	275.80	246.89	219.98	195.04	172.00
62	662.31	611.41	562.97	516.94	473.29	431.96	392.91	356.11	321.50	289.07	258.77	230.57	204.43	180.28	158.08
63	641.80	590.95	542.64	496.81	453.43	412.44	373.81	337.48	303.44	271.64	242.03	214.59	189.24	165.94	144.61
64	621.35	570.55	522.37	476.75	433.66	393.03	354.84	319.05	285.61	254.48	225.63	198.98	174.48	152.05	131.62
65	600.97	550.22	502.17	456.78	413.99	373.76	336.06	300.84	268.05	237.66	209.59	183.78	160.15	138.64	119.15
66	580.64	529.94	482.04	436.88	394.43	354.64	317.47	282.87	250.80	221.18	193.94	169.01	146.30	125.73	107.22
67	560.33	509.68	461.93	417.05	374.98	335.68	299.10	265.18	233.86	205.06	178.70	154.69	132.94	113.36	95.86
68	540.05	489.46	441.90	397.33	355.68	316.92	280.98	247.80	217.28	189.35	163.91	140.87	120.12	101.58	85.14
69	519.90	469.38	422.03	377.80	336.63	298.46	263.21	230.79	201.13	174.10	149.63	127.59	107.89	90.43	75.09
70	499.97	449.53	402.42	358.56	317.90	280.36	245.83	214.23	185.45	159.38	135.90	114.92	96.32	79.98	65.75
71	480.35	430.00	383.14	339.69	299.57	262.68	228.91	198.16	170.30	145.22	122.80	102.92	85.46	70.26	57.13
72	461.09	410.84	364.25	321.23	281.68	245.47	212.49	182.61	155.72	131.68	110.37	91.64	75.34	61.27	49.23
73	442.23	392.08	345.77	303.19	264.22	228.72	196.56	167.61	141.74	118.80	98.64	81.09	65.95	53.00	42.05
74	423.71	373.67	327.66	285.54	247.17	212.42	181.14	153.17	128.38	106.60	87.63	71.27	57.27	45.44	35.56
75	405.48	355.54	309.84	268.21	230.50	196.56	166.21	139.31	115.67	95.09	77.33	62.15	49.30	38.58	29.75
76	387.49	337.68	292.31	251.22	214.22	181.15	151.83	126.07	103.64	84.28	67.73	53.73	42.05	32.42	24.61
77	369.79	320.10	275.10	234.59	198.37	166.26	138.05	113.49	92.29	74.17	58.84	46.05	35.51	26.95	20.12
78	352.36	302.83	258.23	218.36	183.02	151.97	124.93	101.60	81.65	64.77	50.69	39.08	29.67	22.15	16.25
79	335.28	285.90	241.76	202.63	168.25	138.32	112.48	90.39	71.72	56.12	43.27	32.85	24.52	17.99	12.97
80	318.61	269.42	225.82	187.50	154.14	125.35	100.74	79.92	62.54	48.22	36.60	27.33	20.05	14.46	10.24
81	302.57	253.60	210.57	173.11	140.78	113.13	89.75	70.23	54.16	41.11	30.69	22.52	16.23	11.50	8.00
82	287.28	238.54	196.10	159.48	128.16	101.68	79.56	61.35	46.57	34.76	25.51	18.39	13.03	9.06	6.19
83	272.73	224.21	182.33	146.53	116.25	90.97	70.14	53.24	39.75	29.16	21.03	14.89	10.36	7.07	4.74
84	258.66	210.35	169.04	134.11	104.94	80.92	61.42	45.85	33.64	24.26	17.18	11.95	8.16	5.47	3.59
85	244.80	196.73	156.08	122.13	94.17	71.48	53.36	39.16	28.23	20.00	13.91	9.50	6.36	4.17	2.68
86	231.26	183.47	143.57	110.70	84.03	62.73	46.03	33.18	23.50	16.35	11.16	7.48	4.91	3.15	1.98
87	218.27	170.80	131.70	99.97	74.63	54.76	39.48	27.96	19.45	13.28	8.89	5.84	3.75	2.35	1.44
88	205.91	158.77	120.52	89.97	66.01	47.59	33.71	23.45	16.01	10.72	7.04	4.52	2.84	1.73	1.03
89	194.15	147.37	110.02	80.72	58.20	41.22	28.68	19.58	13.11	8.60	5.53	3.47	2.12	1.26	0.73
90	183.01	136.62	100.24	72.27	51.19	35.61	24.32	16.28	10.69	6.86	4.31	2.63	1.57	0.91	0.51
91	172.58	126.63	91.29	64.67	44.99	30.72	20.57	13.50	8.67	5.44	3.33	1.98	1.15	0.64	0.35
92	163.03	117.54	83.25	57.92	39.55	26.48	17.38	11.16	7.00	4.28	2.55	1.47	0.83	0.44	0.23
93	154.41	109.37	76.09	51.95	34.79	22.83	14.66	9.20	5.63	3.35	1.94	1.08	0.58	0.30	0.15
94	146.60	101.99	69.64	46.63	30.60	19.65	12.33	7.54	4.49	2.60	1.45	0.78	0.40	0.20	0.09
95	139.36	95.15	63.72	41.81	26.85	16.85	10.31	6.14	3.55	1.99	1.07	0.55	0.27	0.12	0.05

TABLE 3 - PRESENT VALUE OF LIFE PENSION FOR A FEMALE

Use this table to commute, i.e. determine the present value (PV) of life pension benefits for a female. The "Age on DOC" column refers to the age of the injured employee as of the date of the commutation. The columns labeled "0, 1, 2. . . " refer to the period of years between the DOC and the commencement of life pension, commonly referred to as the "deferral period". The number at the intersection of the row (representing age) and column (representing deferral period) contains the present value at $1 per week for that combination of age and deferral period. Fractional ages and commencement delays can be accommodated using interpolation. See Examples D, E, and F under Commutation Procedures. This table is based on the U.S. Decennial Life Tables for 1989-91.

Age on DOC	Number of years between date of commutation (DOC) and commencement of life pension														
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
15	1475.06	1423.69	1373.83	1325.44	1278.48	1232.92	1188.70	1145.80	1104.17	1063.77	1024.57	986.54	949.64	913.83	879.09
16	1466.91	1415.54	1365.68	1317.30	1270.35	1224.79	1180.59	1137.69	1096.07	1055.68	1016.49	978.47	941.57	905.78	871.05
17	1458.60	1407.23	1357.38	1309.00	1262.06	1216.50	1172.30	1129.41	1087.80	1047.42	1008.23	970.22	933.33	897.55	862.83
18	1450.11	1398.74	1348.89	1300.52	1253.57	1208.03	1163.83	1120.95	1079.33	1038.96	999.78	961.77	924.90	889.12	854.41
19	1441.41	1390.04	1340.19	1291.81	1244.88	1199.33	1155.14	1112.26	1070.65	1030.28	991.11	953.11	916.24	880.47	845.78
20	1432.45	1381.08	1331.24	1282.87	1235.93	1190.39	1146.20	1103.32	1061.72	1021.36	982.20	944.20	907.34	871.59	836.90
21	1423.26	1371.89	1322.04	1273.67	1226.74	1181.20	1137.02	1094.14	1052.55	1012.19	973.03	935.05	898.20	862.46	827.79
22	1413.81	1362.44	1312.59	1264.22	1217.29	1171.76	1127.58	1084.71	1043.12	1002.77	963.62	925.65	888.81	853.08	818.43
23	1404.09	1352.73	1302.88	1254.52	1207.59	1162.05	1117.88	1075.01	1033.43	993.09	953.95	915.99	879.17	843.45	808.82
24	1394.10	1342.73	1292.89	1244.52	1197.60	1152.07	1107.89	1065.04	1023.46	983.13	944.01	906.06	869.25	833.56	798.94
25	1383.82	1332.45	1282.60	1234.24	1187.32	1141.79	1097.63	1054.78	1013.21	972.89	933.78	895.85	859.06	823.38	788.78
26	1373.23	1321.86	1272.02	1223.66	1176.74	1131.22	1087.06	1044.22	1002.67	962.36	923.27	885.35	848.58	812.93	778.35
27	1362.34	1310.97	1261.13	1212.77	1165.86	1120.35	1076.20	1033.37	991.83	951.54	912.46	874.57	837.82	802.19	767.64
28	1351.13	1299.77	1249.93	1201.58	1154.67	1109.17	1065.03	1022.22	980.69	940.42	901.36	863.49	826.76	791.16	756.64
29	1339.64	1288.28	1238.44	1190.10	1143.20	1097.71	1053.58	1010.78	969.27	929.02	889.98	852.13	815.43	779.85	745.37
30	1327.86	1276.49	1226.66	1178.32	1131.43	1085.95	1041.83	999.05	957.56	917.32	878.31	840.48	803.81	768.27	733.82
31	1315.77	1264.41	1214.58	1166.25	1119.37	1073.90	1029.79	987.02	945.55	905.34	866.35	828.55	791.91	756.40	721.99
32	1303.38	1252.02	1202.20	1153.87	1107.00	1061.54	1017.45	974.70	933.24	893.05	854.09	816.32	779.71	744.24	709.88
33	1290.68	1239.32	1189.50	1141.18	1094.31	1048.86	1004.79	962.06	920.62	880.46	841.52	803.79	767.22	731.79	697.48
34	1277.65	1226.29	1176.47	1128.16	1081.30	1035.87	991.81	949.10	907.69	867.55	828.65	790.95	754.43	719.05	684.79
35	1264.28	1212.92	1163.11	1114.80	1067.96	1022.54	978.50	935.81	894.43	854.32	815.45	777.80	741.32	706.00	671.81
36	1250.57	1199.21	1149.41	1101.11	1054.28	1008.87	964.86	922.19	880.84	840.77	801.94	764.34	727.92	692.66	658.54
37	1236.51	1185.16	1135.36	1087.07	1040.25	994.87	950.87	908.24	866.92	826.89	788.11	750.56	714.21	679.02	644.97
38	1222.12	1170.76	1120.97	1072.69	1025.89	980.53	936.56	893.95	852.67	812.69	773.97	736.48	700.20	665.09	631.13
39	1207.37	1156.02	1106.24	1057.97	1011.19	965.84	921.90	879.33	838.10	798.17	759.51	722.09	685.88	650.87	617.01
40	1192.28	1140.93	1091.15	1042.90	996.13	950.82	906.91	864.38	823.20	783.33	744.73	707.40	671.28	636.36	602.61
41	1176.83	1125.48	1075.71	1027.48	980.73	935.45	891.58	849.10	807.97	768.17	729.65	692.40	656.38	621.57	587.95
42	1161.02	1109.68	1059.92	1011.70	964.99	919.74	875.91	833.49	792.43	752.69	714.27	677.11	641.20	606.51	573.02
43	1144.87	1093.54	1043.79	995.59	948.90	903.69	859.92	817.56	776.56	736.92	698.58	661.54	625.75	591.19	557.84
44	1128.37	1077.04	1027.31	979.13	932.48	887.31	843.60	801.30	760.39	720.84	682.61	645.68	610.02	575.61	542.41
45	1111.55	1060.22	1010.51	962.36	915.75	870.63	826.98	784.76	743.94	704.48	666.37	629.57	594.05	559.79	526.77
46	1094.42	1043.10	993.40	945.28	898.71	853.65	810.07	767.93	727.20	687.86	649.88	613.21	577.85	543.76	510.92
47	1076.99	1025.68	976.00	927.92	881.39	836.39	792.89	750.84	710.22	671.00	633.14	596.63	561.43	527.52	494.89
48	1059.29	1007.98	958.32	910.27	863.80	818.87	775.44	733.49	692.98	653.89	616.18	579.83	544.81	511.10	478.69
49	1041.29	989.99	940.36	892.35	845.93	801.07	757.73	715.88	675.50	636.54	598.99	562.81	527.99	494.51	462.32
50	1023.01	971.72	922.10	874.14	827.78	783.00	739.76	698.02	657.77	618.96	581.58	545.60	511.00	477.74	445.81

(Present Value of Life Pension for a Female - con't)

Age on DOC	Number of years between date of commutation (DOC) and commencement of life pension														
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
51	1004.44	953.16	903.58	855.66	809.37	764.67	721.53	679.92	639.81	601.17	563.98	528.21	493.83	460.82	429.16
52	985.64	934.37	884.82	836.95	790.73	746.12	703.09	661.61	621.65	583.20	546.21	510.66	476.52	443.78	412.41
53	966.59	915.33	865.81	818.00	771.85	727.34	684.43	643.09	603.31	565.04	528.27	492.96	459.09	426.63	395.56
54	947.30	896.05	846.57	798.81	752.74	708.33	665.56	624.38	584.78	546.72	510.18	475.12	441.53	409.37	378.63
55	927.76	876.52	827.07	779.38	733.40	689.11	646.47	605.47	566.07	528.23	491.93	457.15	423.86	392.03	361.63
56	907.96	856.74	807.33	759.70	713.82	669.66	627.18	586.37	547.17	509.58	473.55	439.06	406.08	374.59	344.57
57	887.93	836.72	787.36	739.81	694.04	650.02	607.71	567.09	528.13	490.79	455.04	420.87	388.23	357.11	327.49
58	867.69	816.50	767.19	719.73	674.08	630.21	588.09	547.68	508.96	471.89	436.45	402.60	370.33	339.61	310.43
59	847.31	796.14	746.89	699.52	653.99	610.28	568.34	528.16	489.70	452.92	417.80	384.31	352.43	322.14	293.43
60	826.80	775.65	726.45	679.17	633.77	590.23	548.50	508.55	470.36	433.88	399.10	366.00	334.55	304.73	276.52
61	806.13	755.00	705.86	658.68	613.42	570.05	528.54	488.84	450.93	414.79	380.38	347.69	316.70	287.39	259.73
62	785.28	734.18	685.10	638.03	592.92	549.74	508.45	469.02	431.43	395.64	361.64	329.41	298.92	270.15	243.07
63	764.26	713.18	664.18	617.22	572.27	529.29	488.24	449.11	411.85	376.46	342.91	311.17	281.22	253.03	226.57
64	743.09	692.03	643.11	596.27	551.49	508.72	467.94	429.13	392.25	357.29	324.22	293.01	263.64	236.08	210.28
65	721.77	670.74	621.89	575.19	530.58	488.05	447.57	409.11	372.64	338.15	305.61	274.97	246.22	219.32	194.23
66	700.30	649.30	600.54	553.97	509.56	467.30	427.14	389.07	353.05	319.07	287.09	257.07	228.98	202.79	178.47
67	678.66	627.69	579.02	532.61	488.43	446.45	406.66	369.02	333.50	300.08	268.70	239.34	211.96	186.54	163.06
68	656.86	605.92	557.36	511.12	467.20	425.56	386.17	349.00	314.02	281.19	250.46	221.81	195.21	170.64	148.07
69	634.95	584.06	535.61	489.58	445.94	404.67	365.72	329.06	294.66	262.46	232.44	204.56	178.82	155.17	133.57
70	613.01	562.16	513.85	468.05	424.73	383.85	345.38	309.26	275.47	243.96	214.70	187.68	162.86	140.20	119.64
71	591.10	540.30	492.14	446.59	403.61	363.15	325.18	289.65	256.52	225.76	197.34	171.24	147.41	125.80	106.35
72	569.26	518.52	470.52	425.24	382.62	342.61	305.17	270.26	237.85	207.92	180.42	155.31	132.54	112.05	93.75
73	547.52	496.85	449.03	404.02	361.78	322.24	285.38	251.16	219.55	190.51	164.00	139.96	118.32	98.99	81.91
74	525.89	475.27	427.64	382.92	341.08	302.06	265.84	232.38	201.65	173.59	148.14	125.23	104.78	86.69	70.87
75	504.31	453.76	406.32	361.92	320.52	282.08	246.58	213.97	184.19	157.19	132.88	111.18	91.99	75.20	60.67
76	482.73	432.25	385.02	340.98	300.09	262.32	227.63	195.95	167.23	141.37	118.28	97.86	80.00	64.55	51.35
77	461.16	410.77	363.78	320.16	279.86	242.85	209.05	178.41	150.82	126.19	104.41	85.35	68.86	54.78	42.92
78	439.67	389.38	342.69	299.56	259.94	223.77	190.96	161.43	135.07	111.75	91.35	73.71	58.64	45.94	35.43
79	418.43	368.26	321.91	279.33	240.46	205.21	173.48	145.15	120.09	98.17	79.21	63.01	49.37	38.07	28.87
80	397.59	347.55	301.58	259.61	221.56	187.30	156.71	129.66	105.99	85.52	68.03	53.30	41.10	31.17	23.24
81	377.23	327.34	281.79	240.48	203.30	170.09	140.73	115.04	92.82	73.84	57.86	44.61	33.84	25.23	18.47
82	357.39	307.65	262.55	221.95	185.71	153.65	125.60	101.34	80.62	63.17	48.71	36.94	27.54	20.16	14.48
83	338.06	288.51	243.89	204.06	168.84	138.02	111.36	88.59	69.41	53.52	40.59	30.26	22.16	15.92	11.21
84	319.25	269.88	225.81	186.83	152.72	123.23	98.03	76.81	59.22	44.92	33.49	24.52	17.61	12.40	8.56
85	300.95	251.80	208.33	170.30	137.41	109.31	85.65	66.04	50.09	37.34	27.34	19.64	13.83	9.54	6.44
86	283.27	234.38	191.59	154.59	122.98	96.35	74.30	56.35	42.01	30.76	22.09	15.56	10.73	7.25	4.78
87	266.38	217.76	175.70	139.77	109.51	84.44	64.05	47.75	34.96	25.11	17.68	12.20	8.24	5.43	3.49
88	250.27	201.93	160.64	125.86	97.05	73.61	54.88	40.18	28.86	20.32	14.02	9.46	6.24	4.02	2.51
89	234.86	186.83	146.39	112.88	85.61	63.82	46.73	33.57	23.64	16.31	11.01	7.26	4.67	2.92	1.77
90	220.16	172.49	133.01	100.88	75.21	55.06	39.55	27.85	19.21	12.97	8.56	5.50	3.44	2.09	1.23
91	206.39	159.15	120.71	89.99	65.89	47.33	33.33	22.99	15.52	10.24	6.58	4.12	2.50	1.47	0.83
92	193.80	146.99	109.58	80.23	57.63	40.58	28.00	18.90	12.47	8.02	5.02	3.04	1.79	1.01	0.54
93	182.30	135.91	99.51	71.48	50.33	34.72	23.44	15.46	9.95	6.22	3.78	2.21	1.25	0.67	0.34
94	171.64	125.66	90.26	63.56	43.85	29.60	19.53	12.56	7.86	4.77	2.80	1.58	0.85	0.43	0.20
95	161.63	116.10	81.76	56.40	38.08	25.12	16.15	10.11	6.13	3.60	2.03	1.09	0.55	0.26	0.10

Section 10203.1. Aggregate Employer Annual Report (DWC Form GV-1).

STATE OF CALIFORNIA
Department of Industrial Relations
Division of Workers' Compensation
Administrative Director
Post Office Box 420603
San Francisco, CA 94142
Telephone: (415) 703-4600

Aggregate Employer Annual Report

Labor Code §§ 3201.5 and 3201.7; Title 8, California Code of Regulations § 10203

For the 12 month period ending December 31, 20__.

The following information is being obtained by the Administrative Director pursuant to Labor Code §§ 3201.5 and 3201.7, and Title 8, California Code of Regulations Section 10203. This form shall be filed by on or before March 31 of every year by every employer or group of employers participating in a "carve-out" program under Labor Code §§3201.5 or 3201.7. The information provided on this form shall be for the 12 month period ending December 31 of the previous calendar year. The information shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation may create derivative works based on collective bargaining agreements and data. Those derivative works shall not be confidential, but shall be public.

For groups of employers that have received an above-reference letter of eligibility, information obtained from individual employers to provide the information required in this form shall be maintained by the administrator of the Section 3201.5 or 3201.7 program, or the contact person or persons identified in Title 8, California Code of Regulations § 10201(a)(1)(D) and (2)(B), or § 10202(d)(1)(C) and (2)(B). This information may be obtained using the form entitled "Individual Employer Reporting Data" (DWC Form GV-2) (Contained in Title 8, California Code of Regulations § 10203.2. Such information shall be available for inspection by the Administrative Director upon reasonable written request.

Name of Program:
Statute Authorizing Program (circle one): 3201.5 – Construction 3201.7 - Other

1. List all employers with FEIN numbers (Federal Employers Identification Numbers) doing business under the Section 3201.5 or 3201.7 agreement. If you need more space, use separate pages.

Name:
FEIN:

Principal business of employer (please circle one or more):

3201.5: construction construction maintenance
rock, sand, gravel, cement and asphalt operations heavy-duty mechanics
surveying construction inspection

3201.7: education and health services financial activities government
information

leisure and hospitality
manufacturing
natural resources and mining
professional and business services
transportation and utilities
wholesale and retail trade
other (specify)

Name:
FEIN:

Principal business of employer (please circle one or more):

3201.5: construction construction maintenance
rock, sand, gravel, cement and asphalt operations heavy-duty mechanics
surveying construction inspection

3201.7: education and health services financial activities government
information
leisure and hospitality manufacturing natural resources and mining
professional and business services transportation and utilities
wholesale and retail trade other (specify)

Name:
FEIN:

Principal business of employer (please circle one or more):

3201.5: construction construction maintenance
rock, sand, gravel, cement and asphalt operations heavy-duty mechanics
surveying construction inspection

3201.7: education and health services financial activities government
information
leisure and hospitality manufacturing natural resources and mining
professional and business services transportation and utilities
wholesale and retail trade other (specify)

Name:
FEIN:

Principal business of employer (please circle one or more):

3201.5: construction construction maintenance
rock, sand, gravel, cement and asphalt operations heavy-duty mechanics
surveying construction inspection

3201.7: education and health services financial activities government
information
leisure and hospitality manufacturing natural resources and mining
professional and business services transportation and utilities
wholesale and retail trade other (specify)

Name:
FEIN:

Principal business of employer (please circle one or more):

3201.5: construction construction maintenance
rock, sand, gravel, cement and asphalt operations heavy-duty mechanics
surveying construction inspection

3201.7: education and health services financial activities government
information

leisure and hospitality manufacturing natural resources and mining
professional and business services transportation and utilities
wholesale and retail trade other (specify)

2. Name(s) of union(s) participating in the Section 3201.5 or 3201.7 agreement:

3. Dates that the Section 3201.5 or 3201.7 provision was in effect during the previous calendar year:

Beginning date: Ending date:

4. Name of insurer(s):

5. Insurance policy number(s):

5a. If an employer is legally self-insured under authority of the Department of Industrial Relations' Office
of Self-Insurance Plans, list certificate number and name:

6. Name of administrator of ADR system:

7. Address of administrator:

8. Telephone number of administrator: ( )

9. Name of ombudsperson employed in an ADR system (if any):

10. Address of ombudsperson:

11. Telephone number of ombudsperson: ( )
(Note: If there is more than one ombudsperson, attach additional sheets with the required information).

12. Name of mediator employed in an ADR system (if any):

13. Address of mediator:

14. Telephone number of mediator: ( )
(Note: If there is more than one mediator, attach additional sheets with the required information).

15. Name of arbitrator employed in an ADR system (if any):

16. Address of arbitrator:

17. Telephone number of arbitrator: ( )
(Note: If there is more than one arbitrator, attach additional sheets with the required information).

18. Total person hours worked by covered employees, indicate by trade or craft:

Trade: Person Hours:
Trade: Person Hours:
Trade: Person Hours:
Trade: Person Hours:
Trade: Person Hours:

Trade: Person Hours:
Trade: Person Hours:
Trade: Person Hours:
Trade: Person Hours:
Trade: Person Hours:

(Note: If there are more trades represented, attach additional sheets with the required information on person hours worked.)

19. Attach payroll for the employer(s) in accordance with the rules of the Workers' Compensation Insurance Rating Bureau (WCIRB). Payroll shall be reported by class code as set by the WCIRB and provided in table format.

Questions 20 through 45 apply to claims filed in the previous calendar year pursuant to Labor Code §§ 5401 or 5402. For claims with a date of injury on or after January 1, 2003, the information reported shall be for the year in which the claim was filed, and the subsequent calendar years until the claim is resolved. However, information from no more than four calendar years (including the year the claim was filed) shall be reported on each claim.

20. Number of claims that were medical only:

21. Total amount of paid costs for medical only claims:

22. Total amount of incurred costs for medical only claims:

23. Number of claims that included a claim for indemnity:

24. Total amount of paid temporary disability for indemnity claims:

25. Total amount of incurred temporary disability for indemnity claims:

26. Total amount of paid permanent disability for indemnity claims:

27. Total amount of incurred permanent disability for indemnity claims:

28. Total amount of paid life pensions for indemnity claims:

29. Total amount of incurred life pensions for indemnity claims:

30. Total amount of paid death benefits for indemnity claims:

31. Total amount of incurred death benefits for indemnity claims:

32. Total amount of paid vocational rehabilitation for indemnity claims:

33. Total amount of incurred vocational rehabilitation for indemnity claims:

34. Total amount of paid medical services for indemnity claims:

35. Total amount of incurred medical services for indemnity claims:

36. Total amount of paid medical legal expenses for indemnity claims:

37. Total amount of incurred medical legal expenses for indemnity claims:

38. Number of claims that were resolved (resolved means one in which ultimate liability has been determined, even though payments may be made beyond the reporting period):

39. Number of claims that remained unresolved:

Note: The numbers in questions 38 and 39 added together should equal the summation of the number of medical only claims (question 20) and indemnity claims (question 23).

40. The number of claims that were resolved with a denial of compensability:

41. The number of claims that were resolved before mediation:

42. The number of claims that were resolved at or after mediation:

43. The number of claims that were resolved at or after arbitration.

Note: For employers, or group of employers, who utilize a alternative dispute resolution system that includes resolution procedures in addition to or in place of mediation and/or arbitration, please identify on an attachment each resolution procedure used and the number of claims that were resolved using that procedure.

44. The number of claims that were resolved at or after the Workers' Compensation Appeals Board
(WCAB):

45. The number of claims that were resolved at or after the court of appeals:

46. Provide the title and number of every application filed with the WCAB during the previous calendar year concerning the claim alleged by any party to fall within the Section 3201.5 or 3201.7 provision, regardless of whether the employee had the right to file such a application (example in italics):

Title:	*Jane Doe vs. ABC Co*	Number:	*SFO 0123456*
Title:		Number:	
Title:		Number:	
Title:		Number:	
Title:		Number:	
Title:		Number:	
Title:		Number:	

Note: If there are more applications, attach additional sheets with the required information.

47. Provide the title and court number of every civil action, including petitions for writs and injunctions in any court, state or federal, filed in the previous calendar year, that concerned a claim alleged by any party to fall within the Section 3201.5 or 3201.7 provision (example in italics):

Title:	*Jane Doe vs. ABC Co*	Number:	*Alameda County No 3 76052*
Title:		Number:	

Title:	Number:
Title:	Number:
Title:	Number:
Title:	Number:
Title:	Number:
Title:	Number:
Title:	Number:
Title:	Number:

Note: If there are more civil actions, attach additional sheets with the required information.

48. The number of injuries and illnesses reported in the previous calendar year on the United States Department of Labor OSHA Form No. 300 for those employees covered by the Section 3201.5 or 3201.7 provision:

49. The number of employees covered by the Section 3201.5 or 3201.7 provision who participated in vocational rehabilitation:

50. The number of employees covered by the Section 3201.5 or 3201.7 provision who participated in a light duty program or modified return to work programs established under Section 3201.5 or 3201.7:

51. For an employer, or group of employers, who is covered by a 3201.7 provision, please provide an employee survey that measures worker satisfaction with the applicable 3201.7 alternative dispute resolution procedures. The survey shall be designed and administered by agreement between the employer and the union.

52. Please attach any explanatory material, narrative account or comment that you believe would enable the Division to understand your response(s).

Programs are encouraged to submit updated information covering prior calendar year claims reported to Division of Workers' Compensation.

Section 10203.2. Individual Employer Annual Report (DWC Form GV-2).

STATE OF CALIFORNIA
Department of Industrial Relations
Division of Workers' Compensation
Administrative Director
Post Office Box 420603
San Francisco, CA 94142
Telephone: (415) 703-4600

Individual Employer Annual Report

Labor Code §§ 3201.5 and 3201.7; Title 8, California Code of Regulations § 10203

For the 12 month period ending December 31, 20__.

The following information is being obtained by the Administrative Director pursuant to Labor Code §§ 3201.5 and 3201.7, and Title 8, California Code of Regulations Section 10203. An individual employer who is participating in a Section 3201.5 or 3201.7 program with a group of employers shall provide the information requested in this form to the administrator of the Section 3201.5 or 3201.7 program, or the contact person or persons identified in Title 8, California Code of Regulations § 10201(a)(1)(D) and (2)(B) or §10202(d)(1)(C) or (2)(B). The information provided to the program shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation may create derivative works based on collective bargaining agreements and data. Those derivative works shall not be confidential, but shall be public. The information provided by the employer shall be maintained by the administrator of the program and is available for inspection by the Administrative Director upon reasonable written request.

Name of Program:
Statute Authorizing Program (circle one): 3201.5 – Construction 3201.7 - Other

1. Employer Information.

Name:
FEIN:

Principal business of employer (please circle one or more):

3201.5: construction construction maintenance
rock, sand, gravel, cement and asphalt operations heavy-duty mechanics
surveying construction inspection

3201.7: education and health services financial activities government
information
leisure and hospitality manufacturing natural resources and mining
professional and business services transportation and utilities
wholesale and retail trade other (specify)

2. Name of union participating in the Section 3201.5 or 3201.7 agreement:

DWC Form GV-2 (012004)

3. Dates that the Section 3201.5 or 3201.7 provision was in effect during the previous calendar year:

Beginning date: Ending date:

4. Name of insurer:

5. Insurance policy number:

5a. If an employer is legally self-insured under authority of the Department of Industrial Relations' Office of Self-Insurance Plans, list certificate number and name:

6. Attach payroll in accordance with the rules of the Workers' Compensation Insurance Rating Bureau (WCIRB). Payroll shall be reported by class code as set by the WCIRB and provided in table format.

7. Total person hours worked by covered employees, indicate by trade or craft:

Trade: Person Hours:
Trade: Person Hours:
Trade: Person Hours:

(Note: If there are more trades represented, attach additional sheets with the required information on person hours worked.)

Questions 8 through 27 apply to claims filed in the previous calendar year pursuant to Labor Code §§ 5401 or 5402. For claims with a date of injury on or after January 1, 2003, the information reported shall be for the year in which the claim was filed, and the subsequent calendar years until the claim is resolved. However, information from no more than four calendar years (including the year the claim was filed) shall be reported on each claim.

8. Number of claims that were medical only:

9. Total amount of paid costs for medical only claims:

10. Total amount of incurred costs for medical only claims:

11. Number of claims that included a claim for indemnity:

12. Total amount of paid temporary disability for indemnity claims:

13. Total amount of incurred temporary disability for indemnity claims:

14. Total amount of paid permanent disability for indemnity claims:

15. Total amount of incurred permanent disability for indemnity claims:

16. Total amount of paid life pensions for indemnity claims:

17. Total amount of incurred life pensions for indemnity claims:

18. Total amount of paid death benefits for indemnity claims:

19. Total amount of incurred death benefits for indemnity claims:

20. Total amount of paid vocational rehabilitation for indemnity claims:

21. Total amount of incurred vocational rehabilitation for indemnity claims:

22. Total amount of paid medical services for indemnity claims:

23. Total amount of incurred medical services for indemnity claims:

24. Total amount of paid medical legal expenses for indemnity claims:

25. Total amount of incurred medical legal expenses for indemnity claims:

26. Number of claims that were resolved (resolved means one in which ultimate liability has been determined, even though payments may be made beyond the reporting period):

27. Number of claims that remained unresolved:

Note: The numbers in questions 26 and 27 added together should equal the summation of the number of medical only claims (question 8) and indemnity claims (question 11).

28. The number of claims that were resolved with a denial of compensability:

29. The number of claims that were resolved before mediation:

30. The number of claims that were resolved at or after mediation:

31. The number of claims that were resolved at or after arbitration.

Note: For employers who utilize a alternative dispute resolution system that includes resolution procedures in addition to or in place of mediation and/or arbitration, please identify on an attachment each resolution procedure used and the number of claims that were resolved using that procedure.

32. The number of claims that were resolved at or after the Workers' Compensation Appeals Board
(WCAB):

33. The number of claims that were resolved at or after the court of appeals:

34. Provide the title and number of every application filed with the WCAB during the previous calendar year concerning the claim alleged by any party to fall within the Section 3201.5 or 3201.7 provision, regardless of whether the employee had the right to file such a application (example in italics):

Title:	*Jane Doe vs. ABC Co*	Number:	*SFO 0123456*
Title:		Number:	

Note: If there are more applications, attach additional sheets with the required information.

35. Provide the title and court number of every civil action, including petitions for writs and injunctions in any court, state or federal, filed in the previous calendar year, that concerned a claim alleged by any party to fall within the Section 3201.5 or 3201.7 provision (example in italics):

Title:	*Jane Doe vs. ABC Co*	Number:	*Alameda County No 3 76052*
Title:		Number:	

Note: If there are more civil actions, attach additional sheets with the required information.
DWC Form GV-2 (012004)

36. The number of injuries and illnesses reported in the previous calendar year on the United States Department of Labor OSHA Form No. 300 for those employees covered by the Section 3201.5 or 3201.7 provision:

37. The number of employees covered by the Section 3201.5 or 3201.7 provision who participated in vocational rehabilitation:

38. The number of employees covered by the Section 3201.5 or 3201.7 provision who participated in a light duty program or modified return to work programs established under Section 3201.5 or 3201.7:

39. Please attach any explanatory material, narrative account or comment that you believe would enable the Division to understand your response(s).

Programs are encouraged to submit updated information covering prior calendar year claims reported to Division of Workers' Compensation.

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ARTICLE 1. DEFINITIONS AND GENERAL PROVISIONS

New query

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§10210. Definitions.

(a) "Adjudication file" or "ADJ file" means a case file in which the jurisdiction of the Workers' Compensation Appeals Board has been invoked and which is maintained by the Division of Workers' Compensation in paper format, or electronic format, or both, including a temporary paper case file.

(b) "Administrative director" means the administrative director of the Division of Workers' Compensation or his or her designee.

(c) "Appeals board" means the commissioners and deputy commissioners of the Workers' Compensation Appeals Board acting en banc, in panels, or individually.

(d) "Applicant" means any person asserting a right to relief under the provisions of Labor Code section 5300.

(e) "Application for adjudication" or "application" means the initial pleading that asserts a right to relief under the provisions of Labor Code section 5300.

(f) "Central Registration Unit" is a unit within the Division of Workers' Compensation which maintains the website list of uniform names and addresses of claims administrators' offices and representatives' offices.

(g) "Claims administrator's office" means any office location that administers workers' compensation claims.

(h) "Court administrator" means the administrator of the workers' compensation adjudicatory process at the trial level, or his or her designee.

(i) "Declaration of readiness to proceed" or "declaration of readiness" means a request for a proceeding before the district office.

(j) "Declaration of readiness to proceed to expedited hearing" means a request for a proceeding before the district office pursuant to Labor Code section 5502(b).

(k) "Defendant" means any person against whom a right to relief is claimed.

(l) "District office" means a trial level workers' compensation court.

(m) "Document" is a pleading, petition, medical report, record, declaration, exhibit, or another filing submitted by a

party or lien claimant, including an electronically scanned version of a document that was filed in paper form. Each medical report or other record having a different author and/or a different date of service is a separate "document."

(n) "Document cover sheet" means Form 10232.1, which is placed on top of a document or set of documents filed at one time in a specific case.

(o) "Document separator sheet" means Form 10232.2, which is placed on top of each individual document, when one or more documents are being filed at the same time in the same case and placed on top of each individual attachment to each document being filed, when a document has one or more attachments.

(p) "Electronic Adjudication Management System" or "EAMS" means the computerized case management system used by the Division of Workers' Compensation to store and maintain adjudication files and to perform other case management functions.

(q) "Electronic signature" means a signature electronically affixed by a workers' compensation administrative law judge or by the appeals board to any decision, findings, award, order or other document.

(r) "Fax" means a document that has been electronically served by a fax machine.

(s) To "file" a document means to deliver a document or cause it to be delivered to the district office with venue or to the appeals board for the purpose of having it included in the adjudication file.

(t) "Hearing" means any trial, mandatory settlement conference, rating mandatory settlement conference, status conference, lien conference, or priority conference.

(u) "Lien claimant" means any person claiming payment under the provisions of Labor Code section 4903 or 4903.1.

(v) "Lien conference" means a proceeding for the purpose of assisting the parties in resolving disputed lien claims pursuant to Labor Code section 4903 or 4903.1 or, if the dispute cannot be resolved, to frame the issues and stipulations in preparation for a lien trial.

(w) "Mandatory settlement conference" means a proceeding to assist the parties in resolving their dispute or, if the dispute cannot be resolved, to frame the issues and stipulations in preparation for a trial.

(x) "Optical character recognition form" or "OCR form" means a paper form designed to be scanned so that its information is automatically extracted and stored in EAMS.

(y) "Party" means: (1) a person claiming to be an injured employee or the dependent of an injured employee; (2) a defendant; or (3) a lien claimant where either (A) the underlying case of the injured employee or the dependent of an injured employee has been resolved or (B) the injured employee or the dependent of an injured employee chooses not to proceed with his, her, or their case.

(z) "Petition" means any document filed containing a request for action other than an application for adjudication, an answer or a declaration of readiness to proceed.

(aa) "Priority conference" means a proceeding in which the applicant is represented by an attorney and the issues in dispute at the time of the proceeding include employment and/or injury arising out of and in the course of employment.

(bb) "Product delivery unit" means the unit within the Division of Workers' Compensation. The units are abbreviated as follows: Adjudication Unit "ADJ"; Disability Evaluation Unit "DEU"; Subsequent Injuries Benefits Trust Fund "SIF"; Uninsured Employers' Benefits Trust Fund "UEF"; Vocational Rehabilitation "VOC; and Retraining and Return to Work Unit "RSU". For each product delivery unit there is an area in EAMS in which the case management information related to that product delivery unit is stored. That area is called the "product delivery case." "INT" is the

integrated case, which is the umbrella for the individual product delivery cases for each unit residing in EAMS.

(cc) "Rating mandatory settlement conference" means a mandatory settlement conference conducted to facilitate the determination of the existence and extent of permanent disability through the use of informal ratings issued by the Disability Evaluation Unit, where the only unresolved issues are permanent disability and the need for future medical treatment.

(dd) "Representative's office" means any office location for a law firm, lawyer or representative of a party or lien claimant in a workers' compensation case.

(ee) "Regular hearing" means a trial.

(ff) To "serve" a document means to personally deliver a copy of the document, or to send it in a manner permitted by these rules and the rules of the appeals board, to a party, lien claimant, or attorney who is entitled to a copy of the document.

(gg) "Status conference" means a proceeding set for the purpose of ascertaining if there are genuine disputes requiring resolution, of providing assistance to the parties in resolving disputes, of narrowing the issues, and of facilitating preparation for trial if a trial is necessary.

(hh) "Submission" means the closing of the record to the receipt of further evidence or argument.

(ii) "Trial" means a proceeding set for the purpose of receiving evidence.

(jj) "Venue" means the district office, as established by Labor Code section 5501.5 or 5501.6, at which any proceedings will be conducted and from which any district office orders, decisions, or awards will be issued.

(kk) "Workers' compensation administrative law judge" as defined in Labor Code section 123.7 includes pro tempore judges appointed pursuant to California Code of Regulations, title 8, section 10350.

Note: Authority cited: Sections 133 and 5307(c), Labor Code. Reference: Sections 110, 4903, 4903.1, 5300, 5500.3, 5501.5, 5501.6 and 5502, Labor Code.

HISTORY

1. Relocation of subchapter 1.9 from preceding section 10250 to precede section 10210, new article 1 (sections 10210-10214) and new section filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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New query

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§10211. Compliance with Rules of the Court Administrator..

The failure to comply with the rules of the court administrator shall be deemed a bad faith action or tactic that is frivolous or solely intended to cause unnecessary delay unless that failure results from mistake, inadvertence, surprise, or excusable neglect.

Note: Authority cited: Sections 133, 5307(c) and 5500.3, Labor Code. Reference: Section 5813, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§ 10212. District Office Records Not Subject to Subpoena.

(a) The records, files and proceedings of the district office shall not be taken from its offices either on informal request or in response to a subpoena duces tecum or any order issued out of any other court or tribunal. The records, files and proceedings of the district office shall not be produced pursuant a subpoena issued under Labor Code section 130.

(b) Certified copies of portions of the records shall be delivered upon payment of fees as provided in California Code of Regulations, title 8, section 9990.

Note: Authority cited: Sections 133 and 5307(c), Labor Code. Reference: Sections 130, 138.7 and 5955, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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- Register a car wash
- Register for garment manufacturing
- Report a violation of the state Labor Code
- File a complaint with Cal/OSHA
- See labor statistics
- Work for DIR

LINKS

- Industrial Relations databases
- California Labor & Workforce Development Agency
- Economic & Employment Enforcement Coalition
- Employment Development Department
- Sweat-Free Code of Conduct
- U.S. Dept. of Labor

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Please go to the Department's home page at www.dir.ca.gov and relocate the page. You may have to recreate any bookmark in your browser, or notify any external linking site of the change.

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§10214. Compromise and Release Forms and Stipulations with Request for Award Forms.

EAMS forms

The following optical character recognition forms shall be used to settle case by either a compromise and release or stipulation with request for award.

(a) DWC-CA form 10214(a) (Stipulations with request for award) revision dated 11/2008 is incorporated by reference;

(b) DWC-CA form 10214(b) (Stipulations with request for award, death case) dated 11/2008 is incorporated by reference;

(c) DWC-CA form 10214(c) (Compromise and release) revision dated 11/2008 is incorporated by reference;

(d) DWC-CA form 10214(d) (Compromise and release, dependency claim) revision dated 11/2008 is incorporated by reference;

(e) DWC-CA form 10214(e) (Compromise and release, third party settlement) revision dated 11/2008 is incorporated by reference.

Note: Authority cited: Sections 133, 5307(c) and 5500.3, Labor Code. Reference: Sections 5002, 5003, 5004 and 5005, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10215. Case Names and Case Index.

An index of all cases filed with a district office shall be maintained in EAMS under the name of the person claimed to have been injured or the identification assigned to that person, whether or not that person is an applicant. Reference to the case shall be by the name of the injured person and the case number.

Note: Authority cited: Sections 127.5, 133, 5307(c) and 5500.3, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. New article 2 (sections 10215-10225) and section filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§ 10216. Adjudication Files.

(a) All cases filed on and after the effective date of these regulations shall be maintained by the Division of Workers' Compensation in an electronic format in EAMS. All paper documents properly filed in such cases shall be scanned into the EAMS adjudication file and then destroyed no less than 30 business days after filing.

(b) All case opening documents shall be given a case number by the district office where no case number has been previously assigned for the injured worker for the alleged date of injury. The parties shall be notified of the case number by their preferred method of service.

(c) If a case number has been previously assigned by the Division of Workers' Compensation, a new case number will be assigned when a document is filed as follows: the prefix "ADJ" shall replace the previously assigned three letter prefix (i.e. "OAK") and precede the assigned case number.

(d) Except as provided in section 10273, the Division of Workers' Compensation shall maintain a paper adjudication file until it is converted to an electronic adjudication file. If, however, a paper adjudication file is maintained on or after the effective date of these regulations, an electronic adjudication file shall also be created and any documents filed thereafter shall be maintained electronically in EAMS, in accordance with subdivision (c).

(e) A paper adjudication file or a portion of a paper adjudication file may be converted to an electronic adjudication file by the Division of Workers' Compensation at any time. If a paper adjudication file is completely scanned into EAMS the Division of Workers' Compensation shall notify the parties to the case of the change in how the file is maintained; and the paper adjudication file may be destroyed no less than 30 business days after the issuance of the notification.

Note: Authority cited: Sections 127.5, 133, 5307 and 5500.3, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10217. Official Participant Record and Duty to Furnish Correct Address.

(a) The Division of Workers' Compensation shall maintain an official participant record for each adjudication file, which shall contain the names of all parties and lien claimants, and their attorneys or hearing representatives.

(b) In order to ensure case parties and documents are accurately associated to the correct electronic adjudication file, uniform names for claims administrators' offices and representatives' offices shall be used when filing documents in EAMS. The names will be assigned by the Division of Workers' Compensation.

(1) The Division of Workers' Compensation will maintain a list on its website (www.dwc.ca.gov/EAMS) of uniform names and mailing addresses and preferred method of service for the following entities: claims administrators' offices, and representatives' offices.

(2) Additions for new claims administrators' offices and representatives' offices and changes of name, location or address, telephone number, fax number, e-mail address or preferred method of service shall be registered by the entity requesting the change with the Central Registration Unit.

(A) The entity requesting the change must fax or e-mail a letter on letterhead with a signature from an authorized individual requesting the change to the Division of Workers' Compensation's Central Registration Unit within five business days of any change. The entity shall also advise all parties of any change of name, mailing address, or telephone number by furnishing the current information within five business days of any change.

(B) The fax number for the Central Registration Unit is: 1 (888) 822-9309. The e-mail address for the Central Registration Unit is: cru@dir.ca.gov.

(C) The new uniform name or address and preferred method of service will be posted by the Central Registration Unit within ten business days of receipt of the request.

(c) Except as required by subdivision (b), every party and every lien claimant having an interest in an active case pending before the district office or appeals board shall advise the district office and all parties of any change of mailing address and telephone numbers by furnishing the current information within five business days of any change

(d) Every lien claimant that has filed a lien in a case pending in a district office shall advise all parties within five business days of any change in the identity and/or telephone number of the person with authority to resolve the lien by furnishing the correct name and daytime telephone number of that person to the interested parties; and shall advise the Division of Workers' Compensation of any such change after a declaration of readiness is filed.

(e) Every party and lien claimant having an interest in an inactive case: (1) shall advise all other known parties, lien claimants, attorneys, and hearing representative within five business days of any change of address (which shall include any change of mailing address and telephone numbers) by furnishing the correct and current address and/or number; and (2) shall advise the Division of Workers' Compensation of any such change within five business days if there is an outstanding award of further medical treatment or if there is continuing jurisdiction pursuant to Labor Code sections 5410, 5803 and 5804.

Note: Authority cited: Sections 127.5, 133, 5307(c) and 5500.3, Labor Code. Reference: Section 126, 127, 5316, 5410, 5502, 5504, 5803 and 5804, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10218. Designated Preferred Method of Service.

(a) Claims administrators' offices and representatives' offices may designate first class mail, electronic mail or fax as their preferred method of service for receiving documents from the district office and the appeals board. The designated method of service shall be the same for all active cases for that claims administrator's office or representative's office. A party, a lien claimant, or an attorney or other representative for a party or lien claimant who does not or cannot designate a preferred method of service shall be served by first class mail.
(b) A represented party, a lien claimant, or an attorney or other representative for a party or lien claimant may agree with any other represented party, lien claimant, or attorney or other representative for a party or lien claimant that any method of service may be utilized for receiving documents between the parties to the agreement. If such an agreement is made, service pursuant to the agreement shall constitute valid service. Absent such an agreement, service between these parties or entities shall be made by first class mail.

(c) If the service is being made by or on an unrepresented injured worker, unrepresented dependent or unrepresented uninsured employer, then the service shall be made by first class mail.

Note: Authority cited: Sections 127.5, 133, 5307 and 5500.3, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§10222. Failure to Comply with the Court Administrator's Rules.

(a) If a document is not filed in compliance with the court administrator's rules, either because it does not comply with the procedural requirements or with the place of filing requirements, the court administrator may in his or her discretion take the following actions:

(1) Correct the defect and file the document; or

(2) Notify the filer that the document is not accepted for filing by service of a Notice of Document Discrepancy. The Notice shall state the discrepancy, the date of the attempted filing, and provide the filer with 15 business days from service to cure the discrepancy. If the document is corrected within 15 business days, or at a later date upon a showing of good cause, it shall be deemed filed on the original date the document was submitted.

(b) Notwithstanding the provisions of subdivision (a), the following documents shall not be filed with the district office or the appeals board, except as a non duplicative supporting exhibit or upon the order of a workers' compensation administrative law judge or the appeals board. Documents improperly submitted pursuant to this subdivision shall not be accepted for filing or deemed filed and shall not be acknowledged and may be discarded.

(1) letters to opposing parties or counsel;

(2) subpoenas;

(3) notices of taking deposition;

(4) medical appointment letters;

(5) proofs of service ordered pursuant to California Code of Regulations, title 8, section 10500;

(6) medical reports, except as required by section 10233;

(7) copies of any decision of any federal or state court opinion otherwise available.

(8) copies of any decision of the appeals board or a workers' compensation administrative law judge that is otherwise available.

(9) duplicate medical and medical-legal reports.

(10) no diagnostic imaging as defined in Labor Code section 139.3, subd. (b)(1), shall be transmitted to the district office or the appeals board unless it is ordered.

(c) No document shall be sent by electronic mail or by fax directly to the district office or the appeals board. If a document is sent by electronic mail or fax directly to the district office, it shall not be accepted for filing or deemed filed, shall not be acknowledged, and may be discarded unless otherwise ordered by the workers' compensation administrative law judge or the appeals board.

Note: Authority cited: Sections 127, 133, 5307(c) and 5500.3, Labor Code. Reference: Section 126, 5500.3 and 5502, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§ 10223. Corrective Measures for Misfiled or Misdirected Documents into the Case Management System.

(a) The Division of Workers' Compensation may perform document substitution on filed documents; repair scanned documents; and move documents to other adjudication files.

(b) A document substitution may occur where a technical problem of readability and/or legibility exists with a filed document. The filer may seek a substitution of the document by filing a petition to substitute. The proposed document for substitution must be appended to a petition to substitute. If the petition to substitute is granted, the proposed document for substitution will replace the document that was unreadable or illegible.

(c) A document repair may occur where a document scanned into an electronic adjudication file by the Division of Workers' Compensation fails to reflect the original paper document. The Division of Workers' Compensation may repair the document so that the scanned image accurately reflects the original paper document. The Division of Workers' Compensation may repair a document at any time or a party may request a document be repaired. EAMS will retain as viewable the original document for those who have access to the electronic file.

(d) A document may be moved when a document originally scanned by the Division of Workers' Compensation is filed into the wrong electronic file.

(e) Documents that are in the process of being substituted or repaired shall not be moved.

(f) The Division of Workers' Compensation will provide notice to all parties of moved, substituted, or repaired documents within 15 business days.

Note: Authority cited: Sections 127, 133, 5307(c) and 5500.3, Labor Code. Reference: Section 126, 5500.3 and 5502, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10227. Place of Filing Documents After Initial Application or Case Opening Document.

(a) After the filing and processing of an initial application for adjudication of claim or other case opening document, all documents required or permitted to be filed under these regulations or under the rules of the appeals board shall be filed only with the district office having venue, except as provided by the rules of the appeals board, unless otherwise ordered by a workers' compensation administrative law judge or the appeals board.

Note: Authority cited: Sections 133 and 5307(c), Labor Code. Reference: Sections 126 and 5502 Labor Code.

HISTORY

1. New article 3 (sections 10227-10236) and section filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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§10228. Manner of Filing Documents.

(a) Except as provided by section 10603, subd. (a), all documents shall be filed in paper form.

(b) All paper documents shall be scanned into the electronic adjudication file and then destroyed no less than 30 business days after filing, unless otherwise provided by these rules or ordered by a workers' compensation administrative law judge or the appeals board. A scanned document shall have the same legal effect as a document filed in paper form.
(c) Each of the following persons or entities shall file optical character recognition forms completed by using a computer or typewriter with the exception of OCR forms that are prepared at a hearing or that, for good cause, are filed at trial:

(1) any attorneys representing any party or any lien claimant;

(2) any insurance carrier or any representative of any insurance carrier (including any claims adjustor);

(3) any self-insured employer or any representative of a self-insured employer (including any claims adjustor);

(4) any third-party administrator or any representative of a third-party administrator (including any claims adjustor); and

(5) any lien claimant or any representative of any lien claimant, with the exception of: (A) a lien claimant (or a non-attorney representative of a lien claimant) asserting a living expenses lien under Labor Code section 4903(c); (B) a lien claimant (or a non-attorney representative of a lien claimant) asserting a burial expenses lien under Labor Code section 4903(d); or (C) a non-governmental lien claimant (or a non-attorney representative of a lien claimant) asserting a spousal or child support expenses lien under Labor Code section 4903(e).

(d) OCR forms will be posted in fillable format on the Division of Workers' Compensation website (http://www.dir.ca.gov/dwc/forms. html).

(e) All unrepresented employees, unrepresented dependents, unrepresented uninsured employers, or lien claimants listed in subdivision (c)(5)(A), (B) or (C) shall utilize optical character recognition forms, where such forms are required, but if they do not have ready access to a computer or typewriter, printed OCR forms will be available at the

district offices and the information added to the form may be hand-printed in black ink.

(f) Whenever any party or lien claimant files any document utilizing an optical character recognition form, the party or lien claimant shall use the appropriate OCR form required by these rules.

(g) Except as set forth in subdivision (e), any OCR form that was not obtained from the Division of Workers' Compensation's website must function with EAMS in an equivalent manner as the Division's form.

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10229. Electronic Filing Exemption.

If a document is filed with EAMS as part of the electronic filing trial, that document does not need to be filed in compliance with regulation sections 10228 and 10232.

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10230. Time of Filing Documents.

(a) A paper document, including one filed by mail (regardless of when posted), is deemed filed on the date it is received, if received prior to 5 p.m. of a court day (i.e., Monday through Friday, except designated State holidays). A paper document received after 5 p.m. of a court day shall be deemed filed as of the next court day.

(b) When a document is filed by mail or by personal service, the appeals board or the district office that received the document for filing shall affix on it an appropriate endorsement as evidence of receipt. The endorsement may be made by handwriting, hand-stamp, electronic date stamp, or by other means.

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10232. Form and Size Requirements for Filed Documents.

(a) All documents except the medical reports of treating physicians, secondary physicians, qualified or agreed medical evaluators and proposed exhibits, shall be filed in accordance with the following standards:

(1) Only one side of each paper shall be used;

(2) All documents shall be printed with black ink on white paper that is 8 1/2 x11 inches and at least twelve pound weight. All margins shall be at least 1 inch and shall be without typed or handwritten text in any margin;

(3) The first page shall include a case caption that shall include the name of the injured worker or dependent claiming benefits, the name of the employer and the employer's insurer or indicating the employer is self-insured and a case number if one has been assigned by the district office. If a case number has been assigned the number shall be preceded by the abbreviation "ADJ";

(4) All non-form legal pleadings shall contain a heading above the case caption containing the name of the filing attorney and their state bar membership number and the attorney's law firm name and address;

(5) Except as otherwise provided in this section or section 10228(c), all OCR forms and documents shall be printed in Times New Roman, Times, Courier, Palatino, Century Schoolbook or similar serif font of at least 12 points in size;

(6) Except as otherwise provided in section 10228, all text added to the OCR forms shall be in capital letters.

(7) Response to the request on the OCR forms for social security numbers is optional, not mandatory.

(8) A list of body part codes is provided with the document cover sheet form and posted on the Division of Workers' Compensation website (http:// www.dir.ca.gov/forms.html). The codes shall be used on OCR forms to describe the part of the body injured.

(9) A list of district office codes for place of venue is provided with the document cover sheet form and posted on the Division of Workers' Compensation website (http://www.dir.ca.gov/forms.html). The codes shall be used on OCR forms to describe the district office venue.

(10) No single document shall exceed 25 pages in length without the prior permission of the appeals board or the presiding workers' compensation administrative law judge of the district office with venue over the case;

(11) The text of a document shall be double spaced or one and one half spaces; however, captions, headings, headers, footnotes, footers and block quotations shall be single spaced.

(12) The documents shall be flat, without folds and without staples.

(13) OCR forms have bar codes at the top of the document. No other documents shall have bar codes on the top of the document.

(b) All documents shall be filed with document cover sheets and document separator sheets as follows:

(1) A completed document cover sheet shall be the first page of each individual document or set of documents filed at one time in the same case. The cover sheet provides space for information regarding 15 companion cases. Only the pages filled out need to be filed. A document separator sheet shall precede each document within a set of documents.

(2) If an individual document includes an attachment, a completed document separator sheet shall precede the attachment and if an individual document includes multiple attachments, a document separator sheet shall precede each individual attachment. A document separator sheet shall not be placed between a document and the proof of service for that document. Where one proof of service is used for multiple documents, a document separator sheet shall precede the proof of service.

(3) A list of document titles is provided with the document separator sheet form and posted on the Division of Workers' Compensation website (http:// www.dir.ca.gov/forms.html). The document titles shall be used on document separator sheet to describe the attached document.

(4) The document separator sheet requires the filer to list the product delivery units, as defined in section 10210(bb), the date of the attached document, and the author of the attached document.

(5) This subdivision shall not apply to any unrepresented employees, unrepresented dependents or unrepresented uninsured employers who do not have ready access to document cover sheets and document separator sheets.

(c) Oversized documents shall be filed only at the time of trial in accordance with the provisions of section 10603.

(d) If an unrepresented worker, an unrepresented uninsured employer, or an unrepresented dependent does not have ready access to a computer or typewriter and compliance with subdivisions (a)(3) and (a)(5) is not feasible, a hand-printed document may be submitted. Any hand-printed document shall be legible and shall otherwise comply with subdivision (a), including the requirements of subdivision (a)(3) regarding margins and text in the margins.

Note: Authority cited: Sections 133, 5307 and 5500.3, Labor Code. Reference: Sections 126 and 5500.3, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10232.1. Document Cover Sheet Form.

DWC-CA form 10232.1 (Document cover sheet) revision dated 11/2008 is incorporated by reference.

Note: Authority cited: Sections 133, 5307 and 5500.3, Labor Code. Reference: Sections 126 and 5500.3, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10232.2. Document Separator Sheet Form.

DWC-CA form 10232.2 (Document separator sheet) revision dated 11/2008 is incorporated by reference.

Note: Authority cited: Sections 133, 5307 and 5500.3, Labor Code. Reference: Sections 126 and 5500.3, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10233. Filing of Medical Reports, Medical-Legal Reports, and Various Records.

(a) Except as provided by section 10603, medical reports, medical-legal reports, and medical records, and other records and documents shall be filed only in accordance with the following provisions.

(b) This subsection shall apply where a declaration of readiness (other than a declaration of readiness for an expedited hearing) is being filed, including a walk-through declaration of readiness.

(1) When filing a declaration of readiness, the filing party or lien claimant shall file the report of any agreed medical evaluator, any qualified medical evaluator, and any treating physician that: (A) are then in its possession or control, (B) are relevant to the issue being raised by the declaration of readiness, and (C) have not been filed previously. No other medical reports, medical-legal reports, medical records, or other documents shall be filed at that time, unless otherwise ordered by the appeals board or a workers' compensation administrative law judge.

(2) When filing an objection to a declaration of readiness, or within ten days of the filing of the declaration of readiness if no objection is timely filed, each opposing party or lien claimant shall file the report of any agreed medical evaluator, any qualified medical evaluator, and any treating physician that: (A) are then in its possession or control, (B) are relevant to the issue being raised by the declaration of readiness, and (C) have not been filed previously. No other medical reports, medical-legal reports, medical records, or other documents shall be filed at that time, unless otherwise ordered by the appeals board or a workers' compensation administrative law judge.

(c) This subsection shall apply where a declaration of readiness for an expedited hearing is being filed.

(1) When filing a declaration of readiness for an expedited hearing, the filing party or lien claimant shall file the report of any agreed medical evaluator, any qualified medical evaluator, and any treating physician that: (A) are then in its possession or control, (B) are relevant to the issue being raised by the declaration of readiness, and (C) have not been filed previously. No other medical reports, medical-legal reports, medical records, or other documents shall be filed at that time.

(2) When filing an objection to a declaration of readiness for an expedited hearing, or within ten days of the filing of the declaration of readiness if no objection is timely filed, each opposing party or lien claimant shall file the report of any agreed medical evaluator, any qualified medical evaluator, and any treating physician that: (A) are then in its possession or control, (B) are relevant to the issue being raised by the declaration of readiness, and (C) have not been filed previously. No other medical reports, medical-legal reports, medical records, or other documents shall be filed at that time.

(3) All other medical reports, medical-legal reports, medical records, or other documents that are being proposed as exhibits with respect to the issue being raised by the declaration of readiness, and that have not been filed previously, shall be filed at the time of trial, unless otherwise ordered by the appeals board or a workers' compensation administrative law judge.

(d) This subsection shall apply where a compromise and release or a stipulations with request for award is being filed, with the exception that this subsection shall not apply when the compromise and release or the stipulations with request for award is being filed on a walk-through basis in accordance with section 10280.

(1) When filing a compromise and release or a stipulations with request for award, the filing party shall file all agreed medical evaluator reports, qualified medical evaluator reports, treating physician reports, and any other medical records or other records (e.g., wage statements) that: (A) are relevant to a determination of the adequacy of the compromise and release or stipulations with request for award; and (B) have not been filed previously.

(2) If the compromise and release or the stipulations with request for award is not approved, and the matter is set for a hearing on the adequacy of the proposed settlement, any additional reports, records, or other documents not previously filed that are being proposed as exhibits shall be filed at the time of the adequacy hearing, unless otherwise ordered by the appeals board or a workers' compensation administrative law judge.

(3) If the compromise and release or the stipulations with request for award is not approved at or after the adequacy hearing, and the matter is set for a mandatory settlement conference or trial, then any additional medical reports, medical-legal reports, medical records, or other documents that are being proposed as exhibits shall be filed in the same manner as set forth in subsections (g) and (h).

(e) Excerpted portions of relevant physician, hospital or dispensary records shall be filed in accordance with section 10232.

(f) Excerpted portions of relevant personnel records, wage records and statements, job descriptions, and other business records shall be filed in accordance with section 10232.

(g) At a mandatory settlement conference, rating mandatory settlement conference, priority conference or lien conference, all other medical reports, medical-legal reports, medical records, or other documents that are being proposed as exhibits with respect to the issue being raised by the declaration of readiness, and that have not been filed previously, shall be filed, but only if the matter is being set for trial, unless otherwise ordered by the appeals board or a workers' compensation administrative law judge.

(h) At trial, any additional medical reports, medical-legal reports, medical records, or other documents that are being proposed as exhibits with respect to the issue being raised by the declaration of readiness shall be filed, unless otherwise ordered by the appeals board or a workers' compensation administrative law judge.

Note: Authority cited: Sections 133, 5307(c) and 5500.3, Labor Code. Reference: Section 126, 4600, 5500.3 and 5502, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10236. Filing of Copies of Documents.

(a) Except as provided by section 10603, subd. (a), no "original" business, medical, or other documents shall be filed with a district office.

(b) Only a photocopy or other reproduction of an original document shall be filed, and it is presumed the filed document is an accurate representation of the original document.

(c) If a party or lien claimant alleges that a filed document is an inaccurate or unreliable, the party alleging the document is inaccurate or unreliable shall state the basis for the objection. The filing party must establish that the document is an accurate representation of the original document.

(d) A party or lien claimant that elects to retain the original of an exhibit or proposed exhibit need not retain the original after either (1) the exhibit has been authenticated at trial or (2) a settlement that resolves all pending issues has been approved and all appeals have been exhausted or the time for seeking appellate review has expired.

Note: Authority cited: Sections 133, 5307(c) and 5500.3, Labor Code. Reference: Sections 126 and 5500.3, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10240. Appearances Required.

(a) All parties and lien claimants shall appear at all hearings, except as provided below:

(1) Where injury arising out of and in the course of employment is at issue, lien claimants not defined as a party under subdivision 10210(y)(3) shall not be required to appear at the mandatory settlement conference or trial, unless otherwise ordered by the workers' compensation administrative law judge.

(2) Where liability for the claim has been accepted, lien claimants not defined as a party under subdivision 10210(y)(3), with a lien claim of $25,000 or more, shall appear or have a representative appear at the mandatory settlement conference or lien conference, unless the appearance is excused by the workers' compensation administrative law judge.

(3) Lien claimants not defined as a party under subdivision 10210(y)(3) with liens of less than $25,000 shall be available by telephone with settlement authority and shall notify defendant(s) of the telephone number at which the defendant may reach the lien claimants during the mandatory settlement conference or lien conference. The workers' compensation administrative law judge may order the appearance of lien claimants not defined as a party under subdivision 10210(y)(3), with liens of less than $25,000 at a mandatory settlement conference or lien conference.

(4) All lien claimants shall appear at trial at which their lien(s) is an issue to be decided.

(b) All parties shall have a person available with settlement authority at the mandatory settlement conference or lien conference. The person with settlement authority need not be present if an attorney or representative who is present at these proceedings can obtain immediate authority by telephone.

(c) Unless the notice otherwise provides, the applicant shall be present at a mandatory settlement conference as provided in Labor Code section 5502, subd. (e).

(d) Appearance at a hearing not covered under this section shall be at the discretion of the workers' compensation administrative law judge.

Note: Authority cited: Sections 127.5, 133, 5307(c) and 5500.3, Labor Code. Reference: Sections 5502 and 5700,

Labor Code.

HISTORY

1. New article 4 (sections 10240-10246) and section filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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New query

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§10241. Failure to Appear.

(a) Except as provided by section 10603, subd. (a), no "original" business, medical, or other documents shall be filed with a district office.

(a) Where a party or a lien claimant is served with notice of trial pursuant to section 10240 and fails to appear either in person or by attorney or representative, the workers' compensation administrative law judge may:

(1) dismiss the application after issuing a notice of intention to dismiss pursuant to California Code of Regulations, title 8, section 10562;

(2) dismiss the lien claim after issuing a notice of intention to dismiss pursuant to California Code of Regulations, title 8, section 10562;

(3) hear the evidence and, after service of the minutes of hearing and summary of evidence that shall include notice of intention to submit the case for decision pursuant to California Code of Regulations, title 8, section 10562.

(b) Where a party or a lien claimant is served with notice of a conference or mandatory settlement conference pursuant to section 10240 and fails to appear at the conference, the workers' compensation administrative law judge may:

(1) dismiss the application after issuing a notice of intention to dismiss pursuant to California Code of Regulations, title 8, section 10562;

(2) dismiss the lien claim after issuing a notice of intention to dismiss with or without prejudice pursuant to California Code of Regulations, title 8, section 10562;

(3) close discovery and forward the case to the presiding workers' compensation administrative law judge to set for trial.

(c) Where a party, after notice, fails to appear at either a trial or a conference and good cause is shown for failure to appear, the workers' compensation administrative law judge may take the case off calendar or may continue the case to

a date certain.

Note: Authority cited: Sections 133, 5307(c) and 5500.3, Labor Code. Reference: Article XIV, Section 4, California Constitution; and Sections 5502(e) and 5700, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10243. Continuances.

Requests for continuances are inconsistent with the requirement that workers' compensation proceedings be expeditious and are not favored. Continuances will be granted only upon a clear showing of good cause. Where possible, reassignment pursuant to section 10346 shall be used to avoid continuances.

Note: Authority cited: Sections 133 and 5307(c), Labor Code. Reference: Article XIV, Section 4, California Constitution; and Sections 5502 and 5502.5, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10244. Appearances in Settled Cases.

When the parties represent to the workers' compensation administrative law judge assigned to the case that a case has been settled, the case shall be taken off calendar and no appearances shall be required.

Note: Authority cited: Sections 133 and 5307(c), Labor Code. Reference: Article XIV, Section 4, California Constitution; and Sections 5502 and 5502.5, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10245. Minutes of Hearing Form.

DWC-CA form 10245 (Minutes of Hearing form) revision dated 11/2008 is incorporated by reference.

Note: Authority cited: Sections 126, 127.5, 133 and 5307(c), Labor Code. Reference: Sections 5307 (c), 5307.5(b), 5313, 5500.3 and 5502, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10246. Electronically Filed Decisions, Findings, Awards, and Orders.

The district office may electronically file any decision, findings, award, order or other document issued by a workers' compensation administrative law judge. Any document that is electronically filed shall have the same legal effect as a document in paper form.

Note: Authority cited: Sections 127.5, 133 and 5307(c), Labor Code. Reference: Section 5307(c), 5307.5(b) and 5313, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10250. Declaration of Readiness to Proceed.

(a) Applications or petitions shall not be placed on calendar for mandatory settlement conferences, status conferences, priority conferences, expedited hearing or any other hearing unless one of the parties has filed and served a declaration of readiness to proceed in the form prescribed by the court administrator. The declaration of readiness shall be served on all other parties and lien claimants

(b) All declarations of readiness to proceed shall state under penalty of perjury the moving party has made a genuine, good faith effort to resolve the dispute before filing the declarations of readiness to proceed, and shall state with specificity the same on the declarations of readiness to proceed

(c) A false declaration or certification by any party, lien claimant, attorney or representative may give rise to proceedings under Labor Code section 134 for contempt or Labor Code section 5813 for sanctions

(d) If a party or lien claimant is represented by an attorney or representative any declaration of readiness filed on behalf of the party shall be executed by the attorney or representative

Note: Authority cited: Sections 127.5, 133, 5307(c) and 5502(a), Labor Code. Reference: Sections 134, 5500.3, 5502 and 5813, Labor Code.

HISTORY

1. New subchapter 1.9 (section 10250) and section filed 12-31-2003 as an emergency; operative 1-1-2004 (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 4-30-2004 or emergency language will be repealed by operation of law on the following day

2. Certificate of Compliance as to 1-1-2004 order transmitted to OAL 4-30-2004; disapproved by OAL and order of repeal filed 6-15-2004 (Register 2004, No 27)

3. New subchapter 1.9 (section 10250) and section filed 6-30-2004; operative 6-30-2004 pursuant to Government Code section 11343.4 (Register 2004, No 27)

4. Relocation of subchapter 1.9 heading from preceding section 10250 to preceding 10210, new article 5 (sections 10250-10256) and repealer and new section filed 11-17-2008; operative 11-17-2008 pursuant to Government Codesection 11343.4 (Register 2008, No. 47)

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New query

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§10250.1. Declaration of Readiness to Proceed Form.

DWC-CA form 10250.1 (Declaration of Readiness to Proceed form) revision dated 11/2008 is incorporated by reference.

Note: Authority cited: Sections 127.5, 133, 5307(c) and 5502(a), Labor Code. Reference: Sections 5500.3, 5502 and 5813, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§ 10251. Objection to Declaration of Readiness to Proceed.

(a) Any objection to a declaration of readiness to proceed shall be filed and served within ten (10) calendar days after service of the declaration. The objection shall set forth, under penalty of perjury, specific reason why the case should not be set or why the requested proceedings are inappropriate.

(b) A false declaration or certification filed under this section by any party, lien claimant, attorney or representative may give rise to proceedings under Labor Code section 134 for contempt or Labor Code section 5813 for sanctions.

(c) If a party or lien claimant is represented, the attorney or representative shall execute any objection to the declaration of readiness to proceed on behalf of the party. Declarations of readiness to proceed shall be reviewed by the presiding workers' compensation administrative law judge or any workers' compensation administrative law judge designated by the presiding workers' compensation administrative law judge, who will determine on the basis of the facts stated in the declaration whether the objection should be sustained.

(d) If a party has received a copy of the declaration of readiness to proceed and has not filed an objection under this section, that party shall be deemed to have waived any and all objections to proceeding on the issues specified in the declaration, absent extraordinary circumstances.

Note: Authority cited: Sections 127.5, 133, 5307(c) and 5502(a), Labor Code. Reference: Sections 134, 5502 and 5813, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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Subchapter 1.5. Injuries on or After January 1, 1990
SUBCHAPTER 1.9. RULES OF THE COURT ADMINISTRATOR

New query

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§ 10252. Expedited Hearing Calendar

(a) Where injury to any part or parts of the body is accepted as compensable by the employer, a party is entitled to an expedited priority hearing and decision upon the filing of an application for adjudication of claim and a declaration of readiness to proceed pursuant to section 10250 establishing a bona fide, good faith dispute as to:

(1) the employee's entitlement to medical treatment pursuant to Labor Code section 4600;

(2) the employee's entitlement to, or the amount of, temporary disability indemnity payments;

(3) the employee's entitlement to vocational rehabilitation services, or the termination of an employer's liability to provide these services to an employee; or

(4) the employee's entitlement to compensation from one or more responsible employers when two or more employers dispute liability as among themselves.

(b) An expedited hearing may be set upon request where injury to any part or parts of the body is accepted as compensable by the employer and the issues include medical treatment or temporary disability for a disputed body part or parts.

(c) A workers' compensation administrative law judge assigned to a case involving a disputed body part or parts may redesignate the expedited hearing as a mandatory settlement conference, receive a pretrial conference statement pursuant to Labor Code section 5502, subd. (e) (3), close discovery, and schedule the case for trial on the issues presented, if the workers' compensation administrative law judge determines, in consultation with the presiding workers' compensation administrative law judge, that the case is not appropriate for expedited determination.

(d) Grounds for the redesignation of an expedited hearing includes, but is not limited to, cases where the direct and cross-examination of the applicant will be prolonged, or where there are multiple witnesses who will offer extensive testimony.

(e) The parties are expected to submit for decision all matters properly in issue at a single trial and to produce all necessary evidence, including witnesses, documents, medical reports, payroll statements and all other matters considered essential in the proof of a party's claim or defense.

Note: Authority cited: Sections 127.5, 133 and 5502(b), Labor Code. Reference: Section 5502(b), Labor Code.

HISTORY

1. Change without regulatory effect renumbering former section 10136 to section 10252, including amendment of subsection (c), filed 4-7-2008 pursuant to section 100, title 1, California Code of Regulations (Register 2008, No.15).

2. Repealer and new section heading and amendment of section and Note filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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SUBCHAPTER 1.9. RULES OF THE COURT ADMINISTRATOR

New query

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§ 10252.1. Expedited Hearing Form.

DWC-CA form 10252.1 (Expedited Hearing form) revision dated 11/2008 is incorporated by reference.

Note: Authority cited: Sections 127.5, 133 and 5502(b), Labor Code. Reference: Section 5502(b), Labor Code.

HISTORY

1. Change without regulatory effect renumbering former section 10137 to section 10252.1 filed 4-7-2008 pursuant to section 100, title 1, California Code ofRegulations (Register 2008, No. 15).

2. Repealer and new section and amendment of Note filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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New query

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§ 10253. Settlement Conference Calendar.

(a) In accordance with Labor Code section 5502, subd. (e) (2), the workers' compensation administrative law judge shall have authority to inquire into the adequacy and completeness, including provision for lien claims, of compromise and release agreements or stipulations with request for award or orders, and to issue orders approving compromise and release agreements or awards or orders based upon approved stipulations, to make orders and rulings regarding admission of evidence and discovery matters, including admission of offers of proof and stipulations of testimony where appropriate and necessary for resolution of the dispute by the workers' compensation administrative law judge, and may submit and decide the dispute on the record pursuant to the agreement of the parties. The workers' compensation administrative law judge shall not hear sworn testimony at any conference.

(b) The workers' compensation administrative law judge may continue a conference to a time certain to facilitate a specific resolution of the dispute subject to Labor Code section 5502, subd. (e)(1).

(c) Subject to the provisions of Labor Code section 5502.5, upon a showing of good cause, the workers' compensation administrative law judge may continue a mandatory settlement conference to a date certain, may continue it to a status conference on a date certain, or may take the case off calendar. In such a case, the workers' compensation administrative law judge shall note the reasons for the continuance or order taking off calendar in the minutes. The minutes shall be served on all parties and lien claimants, and their representatives.

(d) Absent resolution of the dispute, the parties shall file at the mandatory settlement conference a joint pre-trial conference statement setting forth the issues and stipulations for trial, witnesses, and exhibits.

(e) A summary of conference proceedings including the joint pre-trial conference statement and the disposition shall be filed by the workers' compensation administrative law judge in the adjudication file and shall be served on the parties and lien claimants.

Note: Authority cited: Sections 127.5, 133, 5307(c) and 5502, Labor Code. Reference: Sections 5502 and 5502.5, Labor Code

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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ARTICLE 5. DECLARATIONS OF READINESS TO PROCEED AND OBJECTIONS AND HEARING CALENDARS

New query

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§ 10253.1. Pre-Trial Conference Statement Form.

DWC-CA form 10253.1 (Pre-trial Conference Statement form) revision dated 11/2008 is incorporated by reference.
Note: Authority cited: Sections 133, 5307, 5500.3 and 5502, Labor Code. Reference: Section 5502, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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ARTICLE 5. DECLARATIONS OF READINESS TO PROCEED AND OBJECTIONS AND HEARING CALENDAR

New query

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§10256. Setting the Case.

(a) A presiding workers' compensation administrative law judge or a workers' compensation administrative law judge, using sound discretion, may on his or her own motion set any case for hearing.

(b) The parties are expected to submit for decision all matters properly in issue at a single trial and to produce all necessary evidence, including witnesses, documents, medical reports, payroll statements and all other matters considered essential in the proof of a party's claim or defense. However, a workers' compensation administrative law judge may order that the issues in a case be bifurcated and tried separately upon a showing of good cause.

Note: Authority cited: Sections 127.5, 133, 5307(c) and 5502(a), Labor Code. Reference: Sections 5307(c) and 5502(a), Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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CHAPTER 4.5. DIVISION OF WORKERS' COMPENSATION
SUBCHAPTER 1.9. RULES OF THE COURT ADMINISTRATOR
ARTICLE 6. CONSOLIDATION PROCEDURES

New query

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§10260. Assignment of Consolidated Cases.

(a) Any request or petition to consolidate cases that are assigned to different workers' compensation administrative law judges in the same district office, or that have not been assigned but are venued at the same district office, shall be referred to the presiding workers' compensation administrative law judge of that office, whether the cases involve the same injured worker or multiple injured workers.

(b) Any request or petition to consolidate cases involving the same injured worker that are assigned to workers' compensation administrative law judges at different district offices, or that have not been assigned but are venued at different district offices, shall first be referred to the presiding workers' compensation administrative law judges of the district offices to which the cases are assigned. If the presiding workers' compensation administrative law judges are unable to agree on where the cases will be assigned for hearing, the conflict shall be resolved by the court administrator upon referral by one of the presiding judges.

(c) Any request or petition to consolidate cases involving multiple injured workers that are assigned to workers' compensation administrative law judges at different district offices, or that have not been assigned but are venued at different district offices, shall be referred to the court administrator.

(d) In resolving any request or petition to consolidate cases that are assigned to workers' compensation administrative law judges at different district offices, or that have not been assigned but are venued at different district offices, the court administrator shall set the request or petition for a conference regarding the place of hearing. At or after the conference, the court administrator shall determine the place of hearing and may determine the workers' compensation administrative law judge to whom the cases will be assigned, giving consideration to the factors set forth in California Code of Regulations, title 8, section 10589. In reaching any determination, the court administrator may assign a workers' compensation administrative law judge to hear any discovery motions and disputes relevant to discovery in the action and to report their findings and recommendations to the court administrator.

(e) Any party aggrieved by the determination of the court administrator may request proceedings pursuant to Labor Code section 5310, except that an assignment to a particular workers' compensation administrative law judge shall be challenged only in accordance with the provisions of California Code of Regulations, title 8, sections 10452 and 10453.

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5303 and 5708, Labor Code.

HISTORY

1. New article 6 (section 10260) and section filed 11-17-2008; operative 11-17- 2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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New query

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§10270. Access to and Viewing Adjudication Files.

(a) A party, a lien claimant, or an attorney or other representative for a party or lien claimant may access and view specific adjudication files in which the party, lien claimant, attorney, or representative is a case participant except as provided for in section 10271.

(b) Except as otherwise prohibited by law or sections 10271 and 10272, any person may inspect the contents of any electronic adjudication file at any district office, whether or not the district office has venue over the case.
(c) Except as otherwise prohibited by law or sections 10271 and 10272, any person may inspect the contents of any paper adjudication file at the district office or office of the appeals board where the file is located during regular office hours.

(d) The paper adjudication file and the records and documents contained therein may not be removed from the district office or the office of the appeals board for copying or for any other purpose.

(e) Copying operators must operate their equipment in the room assigned to them and any person copying a paper adjudication file must put papers back in the file in their original order and any person viewing or copying a file must return the file in the same order and condition in which it was received.

(f) A paper adjudication file shall not be sent from one office to another for inspection except for good cause by order of a workers' compensation administrative law judge or the appeals board and upon the payment of a fee required by California Code of Regulations, title 8, section 9990. At the request of a party to the case, or his or her attorney, a paper adjudication file that has been transferred to a record storage center for storage will be made available for inspection through the office from which the file was transferred. Paper adjudication files that have been transferred to a record storage center will be made available for inspection by any other person upon payment of the fee required by California Code of Regulations, title 8, section 9990.

Note: Authority cited: Sections 127.5, 133, 138.7, 5307(c) and 5500.3, Labor Code. Reference: Sections 5502 and 5700, Labor Code.

HISTORY

1. New article 7 (sections 10270-10275) and section filed 11-17-2008; operative11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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New query

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§10271. Prohibitions on Document Inspection.

(a) The following documents shall not be made available for inspection by any person:
(1) Decisions, reports, opinions, orders, recommendations and other documents that are in the process of preparation, or, although fully prepared, have not yet been signed and filed.

(2) Ratings that have not yet been served.

(3) The working papers, personal notes, deliberation records, and other private notations made by a workers' compensation administrative law judge, commissioner, deputy commissioner or appeals board attorney or legal assistant in the course of hearing or deliberation relating to the case.

(4) Any legal memorandum or analysis prepared by a workers' compensation administrative law judge, commissioner, deputy commissioner, appeals board attorney or legal assistant to assist a workers' compensation administrative law judge, deputy commissioner or commissioner in his or her deliberations concerning a case.

Note: Authority cited: Sections 133, 5307(c) and 5500.3, Labor Code; and Section 6253.4, Government Code. Reference: Sections 126, 127 and 138.7, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10272. Sealing Documents.

(a) The presiding workers' compensation administrative law judge or the appeals board may order sealed medical reports, medical records or other documents filed in a case containing references to or discussions of mental or emotional health of any person, sexual habits or practice, use of or addiction to alcohol or other drugs, or other matters of similar character. In a case involving an unrepresented injured employee, the presiding workers' compensation administrative law judge or appeals board may on his, her, or its own motion seal a document or documents after compliance with subdivision (d). Within twenty court days after the order sealing documents, the presiding workers' compensation administrative law judge or the appeals board shall allow the injured worker an opportunity to object to the order.

(b)(1) A party requesting that a document or documents be sealed shall file a petition for an order sealing the requested records. The petition must be accompanied by a memorandum of points and authorities and a declaration containing facts sufficient to justify the sealing.

(2) The party requesting that a record or records be filed under seal must lodge it with the district office under (d) when the petition is filed or with the appeals board if the matter is pending on petition for reconsideration, removal or disqualification, unless good cause exists for not lodging it. Pending the determination of the petition, the lodged records will be conditionally under seal.

(3) If necessary to prevent disclosure, the petition, any opposition, and any supporting documents must be filed in a public redacted version and lodged in a complete version conditionally under seal.

(4) If the presiding workers' compensation administrative law judge or appeals board denies the petition to seal, the clerk must return the lodged record to the submitting party and must not place it in the adjudication file.

(5) A document filed with the district office or appeals board shall not disclose material contained in a previously filed document that is sealed, conditionally under seal, or subject to a pending petition to seal.

(c)(1) The party requesting that a record be filed under seal shall put it in a manila envelope or other appropriate container, seal the envelope or container, and lodge it with the district office or with the appeals board if the matter is pending on petition for reconsideration, removal or disqualification.

(2) The envelope or container lodged with the court must be labeled "CONDITIONALLY UNDER SEAL."

(3) The party submitting the lodged record shall affix to the envelope or container a cover sheet that:

(A) Contains a case number and

(B) States that the enclosed record is subject to a petition to file the record under seal.

(4) Upon receipt of a record lodged under this rule, the district office or the appeals board shall endorse the affixed cover sheet with the date of its receipt and must retain but not file the record unless ordered to do so.

(d) The presiding workers' compensation administrative law judge or the appeals board may order that a document be filed under seal or sealed only if he, she, or it expressly finds facts that establish:

(1) There exists an overriding public interest that overcomes the right of public access to the record;

(2) The overriding public interests supports sealing the record;

(3) A substantial probability exists that the overriding public interest will be prejudiced if the record is not sealed;

(4) The proposed sealing is narrowly tailored; and

(5) No less restrictive means exists to achieve the overriding public interest.

(e)(1) If an order is made that a document or documents be sealed, the order shall be filed in the record of the proceedings. The order shall set forth the facts that support the findings and direct the sealing of only those documents and pages, or if practicable, portions of those documents and pages, that contain the material that needs to be placed under seal.

(2) If the order directs that an entire document shall be sealed, and if the sealed document is contained in a paper adjudication file, the sealed document shall be placed in a sealed envelope, which shall be removed from the file before the file is made available for public inspection. If the sealed document is in an electronic adjudication file, the document shall be marked as sealed. No entirely sealed document in a paper file or an electronic file shall be available for public inspection.

(3) If the order directs that a portion or portions of a document be sealed, and if the partially sealed document is contained in a paper adjudication file, the partially sealed document shall be placed in a sealed envelope, however, a version of the document with the sealed portion redacted shall be made available for public inspection. If the sealed document is in an electronic adjudication file, a version of the document with the sealed portion redacted also shall be electronically maintained and shall be made available for public inspection.

(f) Sealed documents shall be made available for inspection by any party to the case or by his representative, subject to any reasonable conditions and limitations as the presiding workers' compensation administrative law judge or the

appeals board may impose.

(g) Sealed documents shall not otherwise be made available for public inspection except by order of a workers' compensation administrative law judge or the appeals board which shall be made only on a showing that good cause exists to permit the inspection.

Note: Authority cited: Sections 127, 133 and 5307, Labor Code. Reference: Section 5307(c), Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10273. Retention, Return and Destruction of Records and Exhibits.

(a) The Division of Workers' Compensation shall retain for at least fifty years after the filing of case opening documents (i.e., the initial application for adjudication of claim or, where an application has not previously been filed, either a stipulations with request for award or a compromise and release) the following records in a adjudication file, in either electronic or paper form:

(1) the application for adjudication of claim and any amended application;

(2) all settlement documents;

(3) all orders, decisions, or awards;

(4) all minutes of hearing;

(5) all minutes of hearing and summary of evidence;

(6) all medical-legal reports;

(7) all permanent and stationary medical reports of treating physicians;

(8) all rating instructions;

(9) all formal ratings, summary rating determinations, and consultative ratings; and

(10) any other documents as determined by the appeals board, the administrative director, the court administrator.

(b) After five years from the date of filing of the initial application, the Division of Workers' Compensation may eliminate from the adjudication file and destroy paper or electronic correspondence and other miscellaneous material or records, including non-permanent and stationary medical reports of treating physicians, not listed in subdivision (a),

above.

(c) At any time, the Division of Workers' Compensation may eliminate from the adjudication file and destroy any of the following paper or electronic documents:

(1) extra copies of pleadings, notices, findings, orders, decisions, awards and other documents; and

(2) any documents filed in violation of section 10222, subd. (b).

(d) Following a period of fifty (50) years after the filing of the application or other case opening document, the Division of Workers' Compensation may destroy the electronic and/or paper file in each case.

(e) Any party filing an original document or other pieces of evidence pursuant to California Code of Regulations, title 8, section 10603, subd. (a), shall, at the time of filing, either (1) arrange for the return of the document or evidence, at the filing party's sole expense, at the conclusion of all proceedings and appeals thereof; or (2) be deemed by not making such arrangements, to have consented to destruction, without notice, of the document or other evidence at the conclusion of all proceedings and appeals thereof.

(f) Stenographic reporters' notes or electronic sound recording of testimony shall be retained for a period of six (6) years after the taking of them and thereafter may be destroyed or otherwise disposed of.

Note: Authority cited: Sections 133, 5307 and 5500.3, Labor Code. Reference: Section 136, 135 and 5708, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§ 10275. Recording of Trial Level Proceedings.

(a) For the purposes of this section, "recording" means any photographing, recording, or broadcasting of trial level proceedings using video, film, audio, any digital media or other equipment.

(b) Except as provided in this rule, trial level proceedings shall not be photographed, recorded, or broadcast. This rule does not prohibit the Division of Workers' Compensation from photographing or videotaping sessions for judicial education or publications and is not intended to apply to closed- circuit television broadcasts solely within the Division of Workers' Compensation or between Division of Workers' Compensation facilities if the broadcasts are controlled by the Division of Workers' Compensation and Division of Workers' Compensation personnel.

(c) Recording shall be permitted only on written order of the workers' compensation administrative law judge assigned to the case as provided in this subdivision. The workers' compensation administrative law judge in his or her discretion may permit, refuse, limit, or terminate recording.

(1) Any person who wishes to record a trial level proceeding shall make a written request to the presiding workers' compensation administrative law judge for permission to record the proceeding at least five business days before the proceeding commences unless good cause to shorten time is shown. The workers' compensation administrative law judge assigned to the proceeding shall rule upon the request. The district office shall promptly notify the parties that a request has been filed.

(2) The workers' compensation administrative law judge may hold a hearing on the request or rule on the request without a hearing.

(3) In ruling on the request, the workers' compensation administrative law judge shall consider the following factors:

(A) Importance of maintaining public trust and confidence in the workers' compensation system;

(B) Importance of promoting public access to the workers' compensation system;

(C) Parties' support of or opposition to the request;

(D) Nature of the case;

(E) Privacy rights of all participants in the proceeding, including witnesses;

(F) Effect on any minor who is a party, prospective witness, or other participant in the proceeding;

(G) Effect on any ongoing law enforcement activity in the case;

(H) Effect on any subsequent proceedings in the case;

(I) Effect of coverage on the willingness of witnesses to cooperate, including the risk that coverage will engender threats to the health or safety of any witness;

(J) Effect on excluded witnesses who would have access to the televised testimony of prior witnesses;

(K) Security and dignity of the trial level proceeding;

(L) Undue administrative or financial burden to the Division of Workers' Compensation or participants;

(M) Interference with neighboring hearing rooms;

(N) Maintaining orderly conduct of the proceeding;

(O) Any other factor the workers' compensation administrative law judge deems relevant.

(4) The workers' compensation administrative law judge's ruling on the request to permit recording is not required to make findings or a statement of decision. The workers' compensation administrative law judge may condition the order permitting recording of the proceedings on the requestor's agreement to pay any increased costs incurred by the Division of Workers' Compensation resulting from recording the proceeding (for example, for additional security). The requestor shall be responsible for ensuring that any person who records the trial level proceedings on their behalf know and follow the provisions of the order and this rule.

(5) The order permitting recordation may be modified or terminated on the workers' compensation administrative law judge's own motion or upon application to the workers' compensation administrative law judge without the necessity of a prior hearing or written findings. Notice of the application and any modification or termination ordered pursuant to the application shall be given to the parties and each person permitted by the previous order to record the proceeding.

(6) The workers' compensation administrative law judge shall not permit recording of the following:

(A) Proceedings held in chambers which are not transcribed by a hearing reporter;

(B) Proceedings closed to the public; and

(C) Conferences between an attorney and a client, witness, or aide, between attorneys, or between counsel and the workers' compensation administrative law judge at the bench, unless transcribed by a hearing reporter.

(7) The workers' compensation administrative law judge may require a demonstration that people and equipment comply with this rule. The workers' compensation administrative law judge may specify the placement of equipment to minimize disruption of the proceedings.

(8) The following rules shall apply to all recording:

(A) One video recording device and one still photographer shall be permitted.

(B) The equipment used shall not produce distracting sound or light. Signal lights or devices to show when equipment is operating shall not be visible.

(C) Microphones and wiring shall be unobtrusively located in places approved by the workers' compensation administrative law judge and shall be operated by one person.

(D) Operators shall not move equipment or enter or leave the courtroom while the proceeding is in session, or otherwise cause a distraction.

(E) Equipment or clothing shall not bear the insignia or marking of a media agency.

(9) If two or more people request recordation of a proceeding, they shall file a statement of agreed arrangements. If they are unable to agree, the workers' compensation administrative law judge may deny a request to record the proceeding.

(d) Any violation of this rule or an order made under this rule is an unlawful interference with the proceedings may be the basis for an order terminating recording, a citation for contempt, or an order imposing monetary or other sanctions as provided by law.

(e) Notwithstanding (a) through (d), a workers' compensation administrative law judge may permit inconspicuous personal recording devices to be used by parties in a courtroom to make sound recordings as personal notes of the proceedings. A person proposing to use a recording device shall obtain advance permission from the workers' compensation administrative law judge before recording the proceeding. The recording shall not be used for any purpose other than as personal notes, and shall not constitute evidence as to any matter recorded. The right on any individual to use a personal recording device shall be suspended if, in the workers' compensation administrative law judge's sole discretion, it appears that (1) the continued recording of the proceedings will inhibit any party or witness from participation in the proceeding; or (2) the recording is done in a manner that threatens to disrupt the proceeding.

Note: Authority cited: Sections 127, 5307(c) and 5500.3, Labor Code. Reference: Section 5307(c), Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10280. Walk-Through Documents.

(a) A "walk-through" document is a document that is presented to a workers' compensation administrative law judge for immediate action. Notwithstanding the provisions of section 10250 (relating to the filing of declarations of readiness) and section 10544 (relating to notices of hearing), the following provisions shall govern walk-through documents.

(b) Each district office will have a designee of the presiding workers' compensation administrative law judge available to assign walk-through cases from 8:00 a.m. to 11:00 a.m. and 1:00 p.m. to 4:00 p.m. on court days.

(c) The following documents may be submitted on a walk-through basis:

(1) Compromise and releases;

(2) Stipulations with request for award;

(3) Petitions for attorney's fees for representation of the applicant in vocational rehabilitation;

(4) Petitions for attorney's fees for representation of the applicant at a deposition; and

(5) Petitions to compel attendance at a medical examination or deposition.

(d) The following procedures shall be followed for filing walk-through documents:

(1) A walk-through settlement document (i.e., a compromise and release or a stipulations with request for award), and all supporting medical reports and other supporting documents not previously filed, shall be filed directly with the workers' compensation administrative law judge at the date and time of the walk-through. The party presenting the walk-through settlement shall use the appropriate form, document cover sheet, and document separator sheet. Permanent and stationary medical or medical-legal reports shall be indicated as such. In addition, each walk-through settlement document (i.e., a compromise and release or a stipulations with request for award) shall be accompanied by a proof of service showing that the settlement document was served on all other parties to the settlement, on any defendant not executing the settlement who may be liable for the payment of additional compensation, and on all lien claimants whose liens have not been resolved.

(A) A case opening settlement document being submitted for a walk-through shall be submitted no later than noon (12:00 p.m.) of the court day before any action on the walk-through, and shall be designated as a walk-through document. All documents in support of the settlement document shall be submitted at the walk-through with the assigned judge.

(2) A walk-through petition (i.e., a petition for vocational rehabilitation attorney's fees, a petition for deposition attorney's fees, or a petition to compel attendance at a medical examination or deposition) and all other documents relating to the walk-through petition, including any supporting documentation shall be filed directly with the workers' compensation administrative law judge at the date and time of the walk-through. The party presenting the walk-through petition shall use the appropriate form, document cover sheet, and document separator. In addition, at the date and time of the walk-through, the party filing the walk-through petition shall file a proof of service directly to the workers' compensation administrative law judge, as follows:

(A) For a petition for attorney's fees for representation of the applicant in vocational rehabilitation, a proof of service showing service on the injured worker and the defendant alleged to be liable for paying the fees.

(B) For a petition for attorney's fees for representation of the applicant at a deposition, a proof of service showing service on the injured worker and the defendant alleged to be liable for paying the fees.

(C) For a petition to compel attendance at a medical examination or deposition, a proof of service showing service on the injured worker, the injured worker's attorney, and all defendants.

(e) When appearing for the walk-through proceeding, the party filing the walk-through document shall appear before the district office staff person designated by the presiding workers' compensation administrative law judge to assign the walk-through document to a workers' compensation administrative law judge. The filing party shall then appear before the assigned judge. If the assigned judge is unavailable for any reason, the filing party shall then proceed to the presiding workers' compensation administrative law judge for possible reassignment to another judge.

(f) A workers' compensation administrative law judge who is presented with a walk-through settlement document shall approve it, disapprove it, suspend action on it, or accept it for later review and action. If a workers' compensation administrative law judge is presented with so many walk-through settlement documents that review of them will interfere with the cases scheduled before him or her for hearing, the judge may refer the walk-through settlement to the presiding judge for possible reassignment to another judge.

(g) A walk-through document may be acted on only by a workers' compensation administrative law judge at the district office that has venue. If an injured worker has existing cases at two or more district offices that have venue, a walk-through document may be filed at any office having venue over an existing case that is a subject of the walk-through document. An existing case is a case that has been filed and assigned a case number prior to the filing of the walk-through document.

(h) A walk-through document may be acted on by any workers' compensation administrative law judge except as follows:

(1) If a judge has taken testimony, any walk-through document in that case must be acted on by the judge who took testimony if that judge works at the district office to which the case is assigned, unless the presiding judge allows it to be acted on by another judge.

(2) If a judge has reviewed a document and declined to approve it, a walk-through document in that case must be acted on by the same judge, if that judge works at the district office to which the case is assigned, unless the presiding judge allows it to be acted on by another judge.

(i) A workers' compensation judge who is presented with a walk-through petition for attorney's fees or petition to compel attendance shall issue an order in compliance with section 10349.

Note: Authority cited: Sections 127.5, 133 and 5307(c), Labor Code. Reference: Sections 4053, 4054, 5001, 5002, 5702 and 5710, Labor Code.

HISTORY

1. New article 8 (sections 10280-10281) and section filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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New query

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§10281. Emergency Petitions for Stay.

(a) A party may present to the presiding workers' compensation administrative law judge of the district office having venue a petition to stay an action by another party pending a hearing.

(b) Each district office will have a designee of the presiding workers' compensation administrative law judge available to assign petitions for stay from 8:00 a.m. to 11:00 a.m. and 1:00 p.m. to 4:00 p.m. on court days.

(c) A party who walks through a petition to stay an action shall provide notice to the opposing party or parties no later than 10:00 a.m. of the immediately preceding court day. This notice shall: (1) state with specificity the nature of the relief to be requested by the petition to stay; and (2) state the date, time, and place that the petition to stay will be presented. A copy of the petition to stay shall be attached to the notice. The notice shall be given by either fax or e-mail. If notice by fax or e-mail fails, or if an opposing party's fax number or e-mail address are unknown, notice shall be given in the manner best calculated to expeditiously and timely advise the opposing party of the information set forth in subdivisions (c)(1) and (c)(2), including notice by phone or by overnight mail or delivery service. First-class mail shall not be utilized for notice of a petition to stay an action.

(d) A petition to stay an action shall be accompanied by a declaration regarding notice stating under penalty of perjury: (1) the notice given, including the date, time, manner, and name of the party informed; (2) the relief sought; and (3) whether opposition is expected. In addition, if the petitioner was unable to give timely notice to the opposing party, the declaration under penalty of perjury also shall state that the petitioner in good faith attempted to inform the opposing party but was unable to do so, specifying the efforts made to inform the opposing party.
(e) Upon the receipt of a proper petition to stay an action, the presiding workers' compensation or his or her designee shall, in his or her discretion, either: (1) deny the petition; (2) grant a temporary stay and set the petition for a formal hearing; or (3) set the petition for a formal hearing, without either denying the petition or granting a temporary stay.

Note: Authority cited: Sections 127.5, 133 and 5307(c), Labor Code. Reference: Sections 4053, 4054, 4902, 5001, 5002, 5702 and 5710, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10290. Petition Appealing Order Granting or Denying Petition for Order Requiring Employee to Select Employer-Designated Physician.

(a) Upon receipt of a timely petition appealing a decision granting or denying a change of primary treating petition, pursuant to California Code of Regulations, title 8, section 9786, subd. (e) (2) or (e) (3), the matter shall be referred to a workers' compensation administrative law judge for hearing and determination of the issues raised. The petition shall be accompanied by a copy of the administrative director's order, a declaration of readiness, an application for adjudication if one has not been previously filed, and any other documents deemed relevant that have not been previously filed. A party aggrieved by the determination of the workers' compensation administrative law judge may seek relief therefrom within the same time and in the same manner specified for petitions for reconsideration.

(b) Any party aggrieved by an order issued by a workers' compensation administrative law judge pursuant to a referral under California Code of Regulations, title 8, section 9786, subd. (e)(4), of the rules of the administrative director may petition the appeals board for relief therefrom within twenty (20) days from the date of the issuance of the order in the same manner specified for petitions for reconsideration.

Note: Authority cited: Sections 127.5, 133 and 5307(c), Labor Code. Reference: Sections 4603 and 4604, Labor Code.

HISTORY

1. New article 9 (sections 10290-10294.5) and section filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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New query

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§10291. Petition Appealing Notice of Compensation Due.

(a) The petition appealing notice of compensation due shall be served on the injured worker or dependent and on the audit unit, concurrently with its filing.

(b) The petition appealing notice of compensation due shall specify the factual and legal basis for the petition and shall include the audit unit's file number. The petition appealing notice of compensation due shall be accompanied by a copy of the notice of compensation due, a declaration of readiness, an application for adjudication if one has not been previously filed, and any other documents deemed relevant.

(c) If an application for adjudication has not been previously filed, venue shall be designated and determined in accordance with Labor Code section 5501.5 and California Code of Regulations, title 8, section 10409. If an application for adjudication has been previously filed, the petition appealing notice of compensation due shall be filed at the district office having venue and the case number assigned to the application for adjudication shall be assigned to the petition.

(d) An appeal of notice of compensation due shall be set for a hearing before a workers' compensation administrative law judge within forty-five (45) days of filing unless the employee's claim is already before a workers' compensation administrative law judge on other substantive issues in which case the appeal may be considered with these other issues. The audit unit, insurer, self-insured employer or third party administrator and the injured worker shall receive notice of the hearing and copies of subsequent notices of orders issued in the case. Following the hearing, the workers' compensation administrative law judge shall issue findings of fact and an order affirming, modifying or rescinding the notice of compensation due, which complies with Labor Code section 5313.

(e) The copy of the appeal of notice of compensation due sent to the injured worker shall inform the injured worker of the right to consult an attorney. If the injured worker is represented by an attorney, the workers' compensation administrative law judge may determine the amount of attorney fees reasonably incurred in resisting the appeal of notice of compensation due and may assess reasonable attorney fees as a cost upon the employer filing the appeal of notice of compensation due in accordance with Labor Code section 129(c).

Note: Authority cited: Sections 127.5, 133 and 5307(c), Labor Code. Reference: Sections 129, 5300 and 5301, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10293. Petition Appealing Order of the Rehabilitation Unit.

(a) Appeals from decisions of the rehabilitation unit of the Division of Workers' Compensation shall be commenced as follows:

(1) if an application for adjudication is already on file, by filing and serving a declaration of readiness and a petition setting forth the reason for the appeal;

(2) if no application for adjudication is on file, by filing and serving an application for adjudication, a declaration of readiness, and a petition setting forth the reason for the appeal.

(b) The party appealing the rehabilitation unit decision and the party opposing the appeal shall file and serve any documents that the parties deem relevant that have not already been filed in the rehabilitation unit case file.

(c) If an application for adjudication has not been previously filed, venue shall be designated and determined in accordance with Labor Code section 5501.5 and California Code of Regulations, title 8, section 10409. If an application for adjudication has been previously filed, the petition appealing a decision of the rehabilitation unit shall be filed at the district office having venue and the case number assigned to the application for adjudication shall be assigned to the petition.

(d) A petition appealing a decision of the rehabilitation unit shall be filed within twenty (20) days from the date of the issuance of the rehabilitation unit decision.

Note: Authority cited: Sections 127, 133 and 5307(c), Labor Code. Reference: Sections 139.5, 4603, 4604 and 5500, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§ 10294. Petition Appealing Determination of a Return to Work Reimbursement.

(a) An eligible employer may appeal the administrative director's notice under section 10119, subd. (i)(1) and (2), by filing a "Petition Appealing Administrative Director's Reimbursement Allowance," setting forth the basis of the appeal. The petition shall be filed within twenty (20) days from the date of the issuance of the administrative director's notice.

(b) If an application for adjudication has been previously filed, the petition appealing the administrative director's notice shall be filed at the district office having venue and the case number assigned to the application for adjudication shall be assigned to the petition. If an application for adjudication has not been previously filed, an application shall be filed together with the petition, and venue shall be designated and determined in accordance with Labor Code section 5501.5 and California Code of Regulations, title 8, section 10409.

(c) A "Petition Appealing Administrative Director's Reimbursement Allowance" shall be accompanied by a declaration of readiness.

(d) A copy of the petition shall be concurrently served on the administrative director.

Note: Authority cited: Sections 133, 139.48 and 5307.3, Labor Code. Reference: Sections 62.5, 139.48 and 5814.6, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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New query

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§ 10294.5. Petition Appealing Determination Regarding Supplemental Job Displacement Benefits.

(a) Either party may appeal the determination and order of the administrative director issued under California Code of Regulations, title 8, section 10133.54 by filing a petition together with a declaration of readiness to proceed pursuant to section 10250 within twenty calendar days of the issuance of the decision or within twenty days after a request is deemed denied pursuant to California Code of Regulations, title 8, section 10133.54, subd. (f), except that the time for filing shall be extended in accordance with California Code of Regulations, title 8, sections 10507 and 10508. The petition shall set forth the specific factual and legal basis for the appeal.

(b) If an application for adjudication has been previously filed, the petition appealing the administrative director's notice shall be filed at the district office having venue and the case number assigned to the application for adjudication shall be assigned to the petition. If an application for adjudication has not been previously filed, an application shall be filed together with the petition, and venue shall be designated and determined in accordance with Labor Code section 5501.5 and California Code of Regulations, title 8, section 10409.

(c) A copy of the petition shall be concurrently served on the administrative director.

Note: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 4658.5 and 4658.6, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10295. Mandatory Arbitration.

(a) This rule applies to injuries occurring on or after January 1, 1990.

(b) Any application for adjudication that lists one or more disputes involving an issue set forth in Labor Code section 5275, subd. (a), shall be accompanied by an arbitration submittal form. The arbitration submittal form shall indicate that either:

(1) an arbitrator has been selected pursuant to Labor Code section 5271, subd. (a), or

(2) an unsuccessful attempt has been made to select an arbitrator and the presiding workers' compensation administrative law judge is requested pursuant to Labor Code section 5271, subd. (b), to assign a panel of five arbitrators.

(c) If the parties have agreed to an arbitrator pursuant to Labor Code section 5271, subd. (c), the presiding workers' compensation administrative law judge shall, within six (6) days of receipt of the arbitration submittal form, order the issue or issues in dispute submitted for arbitration pursuant to Labor Code sections 5272, 5273, 5276 and 5277.

(d) If the arbitration submittal form requests a panel pursuant to Labor Code section 5271, subd. (b), the presiding workers' compensation administrative law judge shall, within six (6) days of receipt of the arbitration submittal form, serve on each of the parties an identical list of five arbitrators selected at random pursuant to Labor Code 5271, subd. (b). For each party in excess of one party in the capacity of employer and one party in the capacity of injured employee or lien claimant, the presiding workers' compensation administrative law judge shall randomly select two additional arbitrators to add to the panel in accordance with the selection process set forth in Labor Code section 5721, subd. (c). Each of the parties shall strike two arbitrators from the list and return it to the presiding workers' compensation administrative law judge within six (6) days after service. Failure to timely return the list shall constitute a waiver of a party's right to participate in the selection process. If one arbitrator remains, the presiding workers' compensation administrative law judge shall, within six (6) days of return of the lists from the parties, order the issue or issues submitted for arbitration before the selected arbitrator pursuant to Labor Code sections 5272, 5273, 5276 and 5277. If more than one arbitrator remains on the panel, the presiding workers' compensation administrative law judge shall randomly select an arbitrator from the remaining panelists.

(e) If the parties to the dispute have stricken all the arbitrators from the panel, the presiding workers' compensation administrative law judge shall, within six (6) days of receipt of the last of the returned lists, serve on each of the parties to the dispute a new list of five arbitrators and any additional arbitrators required by Labor Code section 5271, subd. (c), selected at random but excluding the names of the arbitrators on the prior list. Each of the parties to the

dispute shall again strike two arbitrators from the list and return it to the presiding workers' compensation administrative law judge within six (6) days after service. This procedure shall continue until one or more arbitrators remain on the lists returned to the presiding workers' compensation administrative law judge.

(f) The parties shall provide all necessary materials to the arbitrator. Any paper file shall remain in the custody of the district office.

(g) A copy of any final decision, order or award from the arbitrator, together with a copy of the record developed as set forth in Labor Code sections 5276 and 5277, shall be filed with the presiding workers' compensation administrative law judge of the district office having venue. The district office shall scan the copies of the arbitrator's the decision, order or award and record into the EAMS adjudication file and, after scanning, shall destroy the copies.

Note: Authority cited: Sections 133 and 5307(c), Labor Code. Reference: Sections 5270-5277, Labor Code.

HISTORY

1. New article 10 (sections 10295-10297) and section filed 11-17-2008; operative 11-17-2008 pursuant to Government Code section 11343.4 (Register 2008, No. 47).

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New query

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§10296. Voluntary Arbitration.

(a) At any time, the parties may agree to submit any issue for arbitration pursuant to Labor Code section 5275, subdivision (b), by submitting an arbitration submittal form that indicates that the parties have selected an arbitrator pursuant to Labor Code section 5271, subdivision (a), and by filing an application for adjudication if one has not been previously filed.

(b) Within six (6) days of receipt of the arbitration submittal form, the presiding workers' compensation administrative law judge shall order the issues in dispute submitted for arbitration pursuant to Labor Code sections 5272, 5273, 5276 and 5277.

(c) If the parties are unable to agree to an arbitrator under Labor Code section 5271, subdivision (a), the parties may agree to follow the procedures for selecting an arbitrator under Labor Code section 5271, subdivisions (b) and (c), as set forth in section 10295.

(d) The parties shall provide all necessary materials to the arbitrator.

(e) A copy of any final decision, order or award from the arbitrator, together with a copy of the record developed as set forth in Labor Code sections 5276 and 5277, shall be filed with the presiding workers' compensation administrative law judge of the district office having venue. The district office shall scan the copies of the arbitrator's decision, order or award and the record into the EAMS adjudication file and, after scanning, shall destroy the copies

Note: Authority cited: Sections 133 and 5307(c), Labor Code. Reference: Sections 5270-5277, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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§10297. Arbitration Submittal Form.

DWC-CA form 10297 (Arbitration Submittal form) revision dated 11/2008 is incorporated by reference.

Note: Authority cited: Sections 133, 5307 and 5500.3, Labor Code. Reference: Section 5275, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008 pursuant to GovernmentCode section 11343.4 (Register 2008, No. 47).

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New query

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§10300. Adoption, Amendment or Rescission of Rules.

Notices required by Labor Code Sections 5307 and 5307.4 shall be served by the Appeals Board by regular mail, fax, electronic mail or any similar technology, not less than thirty (30) days prior to the date of hearing on those who have on file with the Secretary of the Workers' Compensation Appeals Board in San Francisco a written request for notification. Notice of action taken shall be served on the same persons by regular mail within thirty (30) days following the filing of any order pertaining to the rules with the Secretary of State.

NOTE: Authority cited: Section 5307, Labor Code. Reference: Section 5307.4, Labor Code.

HISTORY

1. Repeal of chap. 4.5 (Industrial Accident Commission--Rules of Practice and Procedure) and new chap. 4.5 filed by Industrial Accident Commission 12-27-65; effective thirtieth day thereafter (Register 65, No. 25). For former chap. 4.5, see Registers 58, No. 14; 59, No. 21; 61, No. 9; 61, No. 12; 62, No. 7; 62, No. 21; 63, No. 2; 65, Nos. 5, 13 and 22.

2. Ratification and adoption by Workmen's Compensation Appeals Board, of regulations filed by Industrial Accident Commission on 12-27-65, filed 1-26-66 (Register 66, No. 3).

3. Repealer of subchapter 2 (articles 1-19, sections 10300- 10957, not consecutive and Appendix) and new subchapter 2 (articles 1-20, sections 10300-10958, not consecutive) filed 6- 1-81; designated effective 7-1-81 (Register 81, No. 23). For prior history, see Registers 79, No. 1; 78, No. 3; 77, No. 49; 76, No. 3; 75, No. 35; 75, No. 15; 75, No. 11; 74, No. 6; 73, No. 51; 73, No. 36; 73, No. 6; 68, No. 29; 66, No. 8; 66, No. 7; and 65, No. 25.

4. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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§10301. Definitions.

As used in this subchapter:

(a) "Administrative Director" means the Administrative Director of the Division of Workers' Compensation or his or her designee.

(b) "Adjudication file" or "ADJ file" means a case file in which the jurisdiction of the Workers' Compensation Appeals Board has been invoked and which is maintained by the Division of Workers' Compensation in paper format, electronic format, or both, including a temporary paper case file.

(c) "Appeals Board" means the commissioners and deputy commissioners of the Workers' Compensation Appeals Board acting en banc or in panels.

(d) "Applicant" means any person asserting a right to relief under the provisions of Labor Code Section 5300.

(e) "Application for Adjudication" or "application" means the initial pleading that asserts a right to relief under the provisions of Labor Code Section 5300.

(f) "Carve-out case" means a workers' compensation case that, in accordance with the criteria specified in Labor Code sections 3201.5 through 3201.9, is subject to an alternative dispute resolution (ADR) system that supplements or replaces all or part of the dispute resolution processes contained in Division 4 of the Labor Code.

(g) "Case opening document" means any document that creates an adjudication case and invokes the jurisdiction of the Workers' Compensation Appeals Board for the first time.

(h) "Court Administrator" means the administrator of the workers' compensation adjudicatory process at the trial level, or his or her designee.

(i) "Declaration of Readiness to Proceed" or "Declaration of Readiness" means a request for a proceeding at a district office.

(j) "Declaration of Readiness to Proceed to Expedited Hearing" means a request for a proceeding at a district office pursuant to Labor Code section 5502(b).

(k) "Defendant" means any person against whom a right to relief is claimed.

(l) "District office" means a location of a trial court of the Workers' Compensation Appeals Board.

(m) "Document" is a pleading, petition, medical report, record, declaration, exhibit, or another filing submitted by a party or lien claimant, including an electronically filed document or a scanned version of a document that was filed in paper form. Each medical report or other record having a different author and/or a different date is a separate "document."

(n) "Document cover sheet" means the form adopted by the Court Administrator under section 10232.1, which is placed on top of a document or set of documents being filed at one time in a specific case.

(o) "Document separator sheet" means the form adopted by the Court Administrator under section 10232.2, which is placed on top of each individual document, when one or more documents are being filed at the same time in the same case, and which is placed on top of each individual attachment to each document being filed, when a document has one or more attachments.

(p) "Electronic Adjudication Management System" or "EAMS" means the computerized case management system used by the Division of Workers' Compensation to electronically store and maintain adjudication files and to perform other case management functions.

(q) "Fax" means a document that has been electronically served by a facsimile (fax) machine or other fax technology.

(r) To "file" a document means to deliver a document or cause it to be delivered to the district office with venue or to the Appeals Board for the purpose of having it included in the adjudication file.

(s) "Hearing" means any trial, mandatory settlement conference, rating mandatory settlement conference, status conference, lien conference, or priority conference at a district office or before the Appeals Board.

(t) "Lien claimant" means any person or entity claiming payment under the provisions of Labor Code section 4903 or 4903.1.

(u) "Lien conference" means a proceeding held for the purpose of assisting the parties in resolving disputed lien claims pursuant to Labor Code section 4903 or 4903.1 or, if the dispute cannot be resolved, to frame the issues and stipulations in preparation for a lien trial.

(v) "Mandatory settlement conference" means a proceeding to assist the parties in resolving their dispute or, if the dispute cannot be resolved, to frame the issues and stipulations in preparation for a trial.

(w) "Optical character recognition form" or "OCR form" means a paper form designed to be scanned so that its information is automatically extracted and stored in EAMS.

(x) "Party" means: (1) a person claiming to be an injured employee or the dependent of a deceased employee; (2) a defendant; or (3) a lien claimant where either (A) the underlying case of the injured employee or the dependent(s) of an injured employee has been resolved or (B) the injured employee or the dependent(s) of a deceased employee choose(s) not to proceed with his, her, or their case.

(y) "Petition" means any request for action by the Workers' Compensation Appeals Board other than an Application for Adjudication, an Answer or a Declaration of Readiness to Proceed.

(z) "Priority conference" means a proceeding in which the applicant is represented by an attorney and the issues in dispute at the time of the proceeding include employment and/or injury arising out of and in the course of employment.

(aa) "Rating mandatory settlement conference" means a mandatory settlement conference conducted to facilitate determination of the existence and extent of permanent disability through the use of informal ratings issued by the

Disability Evaluation Unit, where the only unresolved issues are permanent disability and the need for future medical treatment.

(bb) "Regular hearing" means a trial.

(cc) To "serve" a document means to personally deliver a copy of the document, or to send it in a manner permitted by these rules or the rules of the Court Administrator, to a party, lien claimant, or attorney who is entitled to a copy of the document.

(dd) "Status conference" means a proceeding set for the purpose of ascertaining if there are genuine disputes requiring resolution, of providing assistance to the parties in resolving disputes, of narrowing the issues, and of facilitating preparation for trial if a trial is necessary.

(ee) "Submission" means the closing of the record to the receipt of further evidence or argument.

(ff) "Trial" means a proceeding set for the purpose of receiving evidence.

(gg) "Venue" means the district office, as established by Labor Code section 5501.5 or 5501.6, at which any trial level proceedings will be conducted and from which any trial level orders, decisions, or awards will be issued.

(hh) "Workers' Compensation Appeals Board" means the Appeals Board, commissioners, deputy commissioners, presiding workers' compensation judges and workers' compensation judges.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 110, 130, 131, 134, 3201.5 et seq., 4903 et seq., 5300, 5307, 5309, 5310, 5500, 5500.3, 5501, 5501.5, 5501.6, 5502, 5700, 5701 and 5808, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to
Government Code section11351 (Register 2002, No. 51).

2. Amendment of section and Note filed 11-17-2008; operative 11-17-2008.
Submitted to OAL for printing only (Register 2008, No. 47).

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§10302. Working Titles of Workers' Compensation Administrative Law Judges and Presiding Workers' Compensation Administrative Law Judges.

The working titles of "workers' compensation administrative law judge" (formerly, "referee") and "presiding workers' compensation administrative law judge" (formerly, "referee in charge") shall be respectively "workers' compensation judge" and "presiding workers' compensation judge." The term "workers' compensation judge" shall include pro tempore judges appointed pursuant to section 10350.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 27, 123.5, 123.7, 5309, 5310 and 5312, Labor Code.

HISTORY

1. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10304. Article and Section Headings.

Article and section headings shall not be deemed to limit or modify the meaning or intent of the provisions of any section hereof.

Note: Authority cited: Sections 133, 5307, Labor Code. Reference: Sections 133, 5307, Labor Code.

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§10306. Case Names. [Repealed]

10306. Case Names. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. Amendment of section heading and section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10308. Official Address Record. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10322. Workers' Compensation Appeals Board Records Not Subject to Subpoena.

The records, files and proceedings of the Workers' Compensation Appeals Board shall not be taken from its offices either on informal request or in response to a subpoena duces tecum or any order issued out of any other court or tribunal. Except as precluded by Civil Code Section 1798.24, or Government Code Section 6254, certified copies of portions of the records desired by litigants shall be delivered upon payment of fees as provided in the Rules of the Administrative Director.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 127, 5811, Labor Code.

HISTORY

1. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10324. Ex Parte Communications.

(a) No document, including letters or other writings, shall be filed by a party or lien claimant with the Workers' Compensation Appeals Board unless service of a copy thereof is made on all parties together with the filing of a proof of service as provided for in Rule 10505.

(b) When the Appeals Board or a workers' compensation judge receives an ex parte letter or other document from any party or lien claimant in a case pending before the Appeals Board or the workers' compensation judge, he, she, or it shall serve copies of the letter or document on all other parties to the case with a cover letter explaining that the letter or document was received ex parte in violation of this rule.

(c) No party or lien claimant shall discuss with the Appeals Board or a workers' compensation judge the merits of any case pending before the Appeals Board or that judge without the presence of all necessary parties to the proceeding, except as provided by these rules.

(d) All correspondence concerning the examination by and the reports of a physician appointed by a workers' compensation judge or the Appeals Board pursuant to Labor Code section 5701, 5703.5, 5706, or 5906 shall be made, respectively, through the workers' compensation judge or the Appeals Board, and no party, attorney or representative shall communicate with that physician regarding the merits of the case unless ordered to do so.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5701, 5703.5, 5706, 5708 and 5906, Labor Code.

HISTORY

1. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Amendment of section and Note filed 11-17-2008; operative 11-17-2008.
Submitted to OAL for printing only (Register 2008, No. 47).

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§10340. Appeals Board Decisions and Orders.

In accordance with Labor Code Section 115, the following orders, decisions and awards shall be issued only by the Appeals Board:

(a) All orders dismissing, denying and granting petitions for reconsideration and decisions thereon.

(b) All decisions that terminate proceedings on reconsideration, including, but not limited to, findings, orders, awards, orders approving or disapproving compromise and release, orders allowing or disallowing liens, and orders for dismissal.

(c) All orders, including interim and interlocutory orders, made after reconsideration has been granted and while proceedings are pending on reconsideration, including but not limited to, orders taking off calendar, orders joining or dismissing parties, and orders allowing or disallowing liens. Unless otherwise instructed by the Appeals Board, the authority of the workers' compensation judge to whom a case has been referred for proceedings on reconsideration is as set out in Section 10862 of these Rules.

(d) Except for sanctions and contempt, orders in disciplinary proceedings against attorneys or other agents.

(e) Decisions on remittitur.

(f) Orders disqualifying a workers' compensation judge under Labor Code Section 5311.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 115, 5311, Labor Code.

HISTORY

1. Amendment of subsections (b) and (d) filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10341. En Banc Decisions.

En banc decisions of the Appeals Board are binding on panels of the Appeals Board and workers' compensation judges as legal precedent under the principle of stare decisis.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 115, Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10342. Appeals Board, Member Orders.

The following orders may be issued only by the Appeals Board or a member thereof:

(a) approving undertakings on stays of proceedings on reconsideration and petitions for writ of review; and

(b) directing exhumation or autopsy.

NOTE: Authority cited: Sections 133, 5307, Labor Code. Reference: Sections 115, 5706, 5707 and 6002, Labor Code.

HISTORY

1. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10344. Appeals Board, Commissioner, Deputy Commissioner and Presiding Workers' Compensation Judge Orders.

The following may be issued only by the Appeals Board, a commissioner, a deputy commissioner or a presiding workers' compensation judge:

(a) orders issuing certified copies of orders, decisions or awards except that a certified copy may be issued by a presiding workers' compensation judge only if the time for seeking reconsideration and judicial review has expired, and no proceedings are pending on reconsideration or judicial review;

(b) orders staying, quashing and recalling writs of execution and fixing and approving undertaking thereon;

(c) orders directing entry of satisfaction of judgment; and

(d) orders issuing, recalling, quashing, discharging and staying writs of attachment and fixing and approving undertakings thereon.

NOTE: Authority cited: Sections 133, 5307, Labor Code. Reference: Sections 6000, 6001 and 6002, Labor Code.

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§10346. Assignment or Transfer of Cases.

(a) The presiding workers' compensation judge has full responsibility for the assignment of cases to the workers' compensation judges of each office. The presiding workers' compensation judge may utilize EAMS to assign cases. The presiding workers' compensation judge shall transfer to another workers' compensation judge the proceedings on any case in the event of the death, extended absence, unavailability, or disqualification of the workers' compensation judge to whom it has been assigned, and may otherwise reassign those cases if no oral testimony has been received therein, or if the requirements of Labor Code Section 5700 have been waived. To the extent practicable and fair, supplemental proceedings shall be assigned to the workers' compensation judge who heard the original proceedings.

(b) Any conflict that may arise between presiding workers' compensation judges of different offices respecting assignment of a case, venue, or priority of hearing where there is conflict in calendar settings will be resolved by a deputy commissioner of the Appeals Board.

(c) If a compromise and release or stipulations with request for award have not been approved, disapproved, or noticed for trial on the issue of adequacy and other disputed issues within 45 days after filing, the file shall be transferred to the presiding judge for review.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5309 and 5310, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

2. Amendment of section and Note filed 11-17-2008; operative 11-17-2008.
Submitted to OAL for printing only (Register 2008, No. 47).

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§10347. Assignment of Judges. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5309 and 5310, Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51). For prior history, see Register 96, No. 43.

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10348. Authority of Workers' Compensation Judges.

In any case that has been regularly assigned to a workers' compensation judge, the judge shall have full power, jurisdiction and authority to hear and determine all issues of fact and law presented and to issue any interim, interlocutory and final orders, findings, decisions and awards as may be necessary to the full adjudication of the case, including the fixing of the amount of the bond required in Labor Code section 3715. Orders, findings, decisions and awards issued by a workers' compensation judge shall be the orders, findings, decisions and awards of the Workers' Compensation Appeals Board unless reconsideration is granted.

A workers' compensation judge or a deputy commissioner may issue writs or summons, warrants of attachment, warrants of commitment and all necessary process in proceedings for direct and hybrid contempt in a like manner and to the same extent as courts of record.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 121, 134, 5309 and 5310, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment of first paragraph filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10349. Orders Equivalent to Notices of Intention.

An order with a clause rendering the order null and void if an objection showing good cause is filed within ten (10) days shall be deemed equivalent to a ten (10) day notice of intention.

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section !, Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51). For prior history, see Register 96, No. 43.

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§10350. Trials: Appointment and Authority of Pro Tempore Workers' Compensation Judges.

A presiding workers' compensation judge may appoint and assign a pro tempore workers' compensation judge to conduct a trial on any issue in any proceeding before the Workers' Compensation Appeals Board and to make and file a finding, opinion, order, decision or award based thereon. Before assignment of a particular pro tempore workers' compensation judge, the parties or their representatives shall submit a request and written stipulation to the presiding workers' compensation judge. The request and written stipulation shall set out in full the name and the office address of the attorney agreed upon to conduct the trial as a pro tempore workers' compensation judge.

If a case is off calendar or has not before been set on the trial calendar, the request and written stipulation must be filed with a Declaration of Readiness to Proceed pursuant to Section 10414. The presiding workers' compensation judge, upon approval of the request for trial by a pro tempore workers' compensation judge, will assign the case to the trial calendar making appropriate arrangements to provide the pro tempore workers' compensation judge with facilities and staff at a time and place convenient to the Workers' Compensation Appeals Board and the pro tempore workers' compensation judge.

At the time of any conference hearing, the parties or their representatives may file the same request and written stipulation which will be submitted to the presiding workers' compensation judge who will assign the case to the trial calendar in the same manner as set forth above.

Pro tempore workers' compensation judges will have all the authority and powers of workers' compensation judges as set forth in the Labor Code and Rules of Practice and Procedure of the Workers' Compensation Appeals Board including inquiry into adequacy of and approval of compromise and release agreements and stipulated findings including the authority to issue appropriate findings, awards and orders. Pro tempore workers' compensation judges shall be bound by the Rules of Practice and Procedure of the Workers' Compensation Appeals Board (including Articles 6, 7 and 8).

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 123.7, 5309 and 5310, Labor Code.

HISTORY

1. New section filed 5-25-82; designated effective 7-1-82 (Register 82, No. 22).

2. Amendment of section heading, section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10351. Conference Hearings: Appointment and Authority of Pro Tempore Workers' Compensation Judges.

A pro tempore workers' compensation judge shall in any case filed have the same power as a workers' compensation judge to conduct conference hearings, including mandatory settlement conferences, rating mandatory settlement conferences and status conferences; to inquire into the adequacy of and to approve compromise and release agreements; to approve stipulated findings and to issue appropriate awards based on the stipulations; to frame stipulations and issues and make interim and interlocutory orders at the conference hearing.

The presiding workers' compensation judge may assign a pro tempore workers' compensation judge to any conference hearing calendar including rating mandatory settlement conferences or status conferences. The name of the pro tempore workers' compensation judge shall appear on the notice of hearing. Failure to object to the assignment within five days of service of notice of conference hearing shall constitute a waiver of any objection to proceeding before the pro tempore workers' compensation judge assigned to the mandatory settlement conference hearing, rating mandatory settlement conference or status conference

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 123.7, 5309 and 5310, Labor Code.

HISTORY

1. New section filed 5-25-82; designated effective 7-1-82 (Register 82, No. 22).

2. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10352. Reconsideration of Pro Tempore Workers' Compensation Judge's Orders, Decisions or Awards.

Any final order, decision or award filed by a pro tempore workers' compensation judge shall be subject to the reconsideration process as set forth in Labor Code Sections 5900 through 5911.

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 121, 123.7, 5309, 5310 and 5900-5911, Labor Code.

HISTORY

1. New section filed 5-25-82; designated effective 7-1-82 (Register 82, No. 22).

2. Editorial correction of NOTE filed 2-2-83 (Register 83, No. 6).

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§10353. Settlement Conference Authority.

(a) In accordance with Labor Code section 5502, subdivision (e)(2), the workers' compensation judge shall have authority to inquire into the adequacy and completeness, including provision for lien claims, of compromise and release agreements or stipulations with request for award or orders, and to issue orders approving compromise and release agreements or awards or orders based upon approved stipulations. The workers' compensation judge may make orders and rulings regarding admission of evidence and discovery matters, including admission of offers of proof and stipulations of testimony where appropriate and necessary for resolution of the dispute(s) by the workers' compensation judge, and may submit and decide the dispute(s) on the record pursuant to the agreement of the parties. The workers' compensation judge shall not hear sworn testimony at any conference.

(b) The workers' compensation judge may temporarily adjourn a conference to a time certain to facilitate a specific resolution of the dispute(s) subject to Labor Code section 5502, subdivision (e)(1).

Subject to the provisions of Labor Code Section 5502.5 and Rule 10416, upon a showing of good cause, the workers' compensation judge may continue a mandatory settlement conference to a date certain, may continue it to a status conference on a date certain, or may take the case off calendar. In such a case, the workers' compensation judge shall note the reasons for the continuance or order taking off calendar in the minutes. The minutes shall be served on all parties and lien claimants, and their representatives.

(c) Absent resolution of the dispute(s), the parties shall file at the mandatory settlement conference a joint pre-trial statement setting forth the issues and stipulations for trial, witnesses, exhibits, and the proposed permanent disability rating as provided by Labor Code Section 4065. The parties may modify their proposed ratings only when evidence, relevant to the proposed ratings, and disclosed or obtained after the mandatory settlement conference, becomes admissible pursuant to Labor Code Section 5502, subdivision (e)(3).

A summary of conference proceedings including the joint pre-trial conference statement and the disposition shall be filed by the workers' compensation judge in the record of the proceedings on a form prescribed and approved by the Appeals Board and shall be served on the parties.

NOTE

Authority cited: Sections 133, 5307 and 5502, Labor Code. Reference: Sections 5502 and 5502.5, Labor Code.

HISTORY

1. New section exempt from OAL review pursuant to Government Code section 11351, filed 12-19-90; operative 1-1-

91 (Register 91, No. 7).

2. Amendment of section heading and text filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

3. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10360. Necessary Parties.

Any applicant other than the injured employee shall join the injured employee as a party. In such instances the Application for Adjudication shall include the injured employee's address if known or, if not known, a statement of that fact.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 126, 5307.5 and 5503, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10364. Parties Applicant.

(a) Any person in whom any right to relief is alleged to exist may appear, or be joined, as an applicant in any case or controversy before the Workers' Compensation Appeals Board. A lien claimant may become a party where the applicant's case has been settled by way of a compromise and release, or where the applicant chooses not to proceed with his or her case.

(b) Any person against whom any right to relief is alleged to exist may be joined as a defendant.

(c) In death cases, all persons who may be dependents shall either join or be joined as applicants so that the entire liability of the employer or the insurer may be determined in one proceeding.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5300, 5303, 5307.5, 5500 and 5503, Labor Code.

HISTORY

1. New subsection (a) designator and new subsections (b) and (c) filed 10-21-96; operative 11-1-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 43).

2. Amendment of subsection (a) filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10368. Parties Defendant. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5300, 5303, 5307.5, 5500 and 5503, Labor Code.

HISTORY

1. Repealer filed 10-21-96; operative 11-1-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 43).

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§10372. Parties in Death Cases. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5300, 5303, 5307.5, 5500 and 5503, Labor Code.

HISTORY

1. Repealer filed 10-21-96; operative 11-1-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 43).

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§10380. Joinder of Parties.

After filing of an Application for Adjudication, the Appeals Board, a workers' compensation judge may order the joinder of additional parties necessary for the full adjudication of the case. A party not present or represented at the time of joinder shall be served with copies of the order of joinder, the application, minutes of hearing and summary of evidence, medical reports and other documents, as directed in the order of joinder. The Workers' Compensation Appeals Board may designate the party or parties who are to make service.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5307.5 and 5316, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section 11351, filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10390. Place and Time of Filing Documents. (Repealed)

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. Repealer and new section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

3. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10392. Form and Size Requirements for Filed Documents. (Repealed)

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

3. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10391. Filing of Copies of Documents. (Repealed)

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10395. Improper Filing of Documents. (Repealed)

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. New section filed 5-25-82; designated effective 7-1-82 (Register 82, No. 22).

2. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

3. New subsections (e)-(f), subsection relettering and amendment of last paragraph filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

4. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10396. Duty to Furnish Correct Address. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10397.10397. Restrictions on the Rejection for Filing of Documents Subject to a Statute of Limitations or a Jurisdictional Time Limitation.

(a) An application for adjudication of claim, a petition for reconsideration, a petition to reopen, or any other petition or other document that is subject to a statute of limitations or a jurisdictional time limitation shall not be rejected for filing solely on the basis that:

(1) the document is not filed in the proper office of the Workers' Compensation Appeals Board;

(2) the document has been submitted without the proper form, or it has been submitted with a form that is either incomplete or contains inaccurate information; or

(3) the document has not been submitted with the required document cover sheet and/or document separator sheet(s), or it has been submitted with a document cover sheet and/or document separator sheet(s) not containing all of the required information.

(b) A document that is subject to a statute of limitations or a jurisdictional time limitation may be rejected for filing if it does not contain a combination of information sufficient to establish the case or cases to which the document relates or, if it is a case opening document, sufficient information to open an adjudication file. If a document is rejected in accordance with this subdivision, the Court Administrator shall return the document to the filer and shall notify the filer, through the service of a Notice of Document Discrepancy, that the document has not been accepted for filing. The Notice of Document Discrepancy shall specify the nature of the discrepancy(ies) and the date of the attempted filing, and it shall state that the filer shall have 15 days from the service of the Notice within which to correct the discrepancy(ies) and resubmit the document for filing. If the document is corrected and resubmitted for filing within 15 days, or at a later date upon a showing of good cause, it shall be deemed filed as of the original date the document was submitted.

(d) Nothing in this section shall preclude the discretionary or conditional acceptance for filing of a document that is subject to a statute of limitations or a jurisdictional time limitation, even if it does not contain a combination of information sufficient to establish the case or cases to which the document relates or, if it is a case opening document, sufficient information to open an adjudication file.

(e) Where document that it is subject to a statute of limitations or a jurisdictional time limitation has been accepted for filing in accordance with this rule, but the document nevertheless cannot be processed by EAMS, the Court

Administrator may serve a copy of the filed document on the filing party or lien claimant, together with a Notice of Document Discrepancy. The notice may specify the nature of the discrepancy(ies) and request that the party correct the discrepancy(ies) within 15 days after service of the Notice, however, a failure to timely correct the discrepancy(ies) shall not nullify the acceptance of the document for filing.

(f) Nothing in this section shall be deemed to excuse non-compliance with any of other provisions of the rules of the Workers' Compensation Appeals Board or non-compliance with the rules the Court Administrator. Any such non-compliance may still be a basis for the imposition of sanctions under Labor Code section 5813 and Rule 10561.

Note: Authority cited: Article XIV, Section 4, California Constitution; Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 126, 5316, 5500 and 5501, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10400. Applications.

(a) Except as provided by sections 10865 and 10953, proceedings for the adjudication of rights and liabilities before the Workers' Compensation Appeals Board shall be initiated by the filing of an Application for Adjudication, a case opening Compromise and Release Agreement, a case opening Stipulations with Request for Award, or a Request for Findings of Fact under section 10405.

(b) A case opening Compromise and Release Agreement, a case opening Stipulations with Request for Award, and a Request for Findings of Fact under section 10405 are each an "application" for purposes of invoking the jurisdiction of the Workers' Compensation Appeals Board, but none of these documents shall be deemed an application for purposes of Labor Code section 4064(c).

(c) Upon the filing of an initial application, the application shall be assigned an adjudication case number and a venue.

(d) When filing an amended application, the applicant shall indicate on the box set forth on the application form that it is an "amended" application.

(e) Upon filing an Application for Adjudication, the filing party or lien claimant shall concurrently serve a copy of the application and any accompanying documents on all other parties and lien claimants.

(f) If the party filing the application is an unrepresented injured employee, an unrepresented dependent of a deceased employee, or a lien claimant or non-attorney representative of a lien claimant who falls within one of the exceptions of section 10228, subdivisions (c)(5)(A) through (c)(5)(C), the Workers' Compensation Appeals Board:

(1) shall serve a conformed copy of the application on all parties and lien claimants, including the filing applicant, who are listed on either on the application, on the proof of service to the application, or on the address record (if an address record was previously created for an earlier application); and

(2) if it is an initial application, shall concurrently give notification of the assigned adjudication case number and venue.

Such service shall be deemed service of a conformed copy of the application for purposes of Labor Code section 5501.

(g) For all other parties and lien claimants, the Workers' Compensation Appeals Board:

(1) shall serve a conformed copy of the application on the filing party or lien claimant (or, if represented, on the filing party or lien claimant's attorney or other representative); and

(2) if it is an initial application, shall concurrently give notification of the assigned adjudication case number and venue.

Upon receipt of the conformed copy of the application, the filing party or lien claimant (or, if represented, the filing party or lien claimant's attorney or other representative) shall forthwith serve a copy of the conformed application on all other parties and lien claimants who are listed on the application or on the proof of service to the application, and, if it is an initial application, shall concurrently notify all other parties and lien claimants of the assigned adjudication case number and venue.

Such service shall be deemed service of a conformed copy of the application for purposes of Labor Code section 5501.

(h) Disclosure of the applicant's Social Security number is voluntary, not mandatory. A failure to provide a Social Security number will not have any adverse consequences. Nevertheless, although an applicant is not required by law to provide a Social Security number, he or she is encouraged to do so. Social Security numbers are used solely for identification and verification purposes in order to administer the workers' compensation system. A Social Security number will not be disclosed, made available, or otherwise used for purposes other than those specified, except with the consent of the applicant, or as permitted or required by statute, regulation, or judicial order.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 126, 5316, 5500 and 5501, Labor Code.

HISTORY

1. Repealer and new section exempt from OAL review pursuant to GovernmentCode section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment of section filed 6-11-92 with Secretary of State by Workers' Compensation Appeals Board; operative 6-11-92. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 92, No. 24).

3. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

4. Editorial correction of article heading (Register 93, No. 53).

5. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

6. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10401. Separate Application for Each Injury.

A separate Application for Adjudication shall be filed for each separate injury for which benefits are claimed even though the employer is the same in each case. Separate pleadings shall be filed in each case.

All claims of all persons arising out of the same injury to the same employee shall be filed in the same proceeding.

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 3208.2 and 5500, Labor Code.

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§10402. Minors, Incompetents as Applicants.

If the Applicant is a minor or incompetent, the Application for Adjudication shall be accompanied by a Petition for Appointment of a Guardian ad Litem and Trustee. In those instances where the minor has the right of nomination, the nomination shall be included in the petition.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5307.5 and 5500, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Repealer of second paragraph filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10403. Application Required Before Jurisdiction Invoked and Before Compelled Discovery May Be Commenced.

The jurisdiction of the Workers' Compensation Appeals Board is invoked only by the filing of an initial Application for Adjudication of Claim or other case opening document. The pre-application assignment of a non-adjudication EAMS case number by any ancillary unit of the Division of Workers' Compensation (e.g., the Disability Evaluation Unit, the Information and Assistance Office, the Rehabilitation Unit, or the Retraining and Return to Work Unit):
(a) does not establish the jurisdiction of the Workers' Compensation Appeals Board and, therefore, does not permit it to conduct any hearings or to issue any orders;

(b) does not toll the statute of limitations (except as provided in Labor Code section 5454 for submissions to the Information and Assistance Unit); and

(c) does not authorize the commencement of formal, compelled discovery.

Nothing in this section shall be construed to preclude any non-compelled pre-application medical evaluations or investigations.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5300, 5301 and 5500, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47). For prior history, see Register 92, No. 24.

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§10404. Labor Code Section 4906(g) Statement.

The employee, insurer, employer and the attorneys for each party shall comply with Labor Code Section 4906(g) by filing a statement under penalty of perjury wherein it is declared that the party on whose behalf the declaration is made has not violated Labor Code Section 139.3, has not offered, delivered, received, or accepted any unlawful rebate, refund, commission, preference, patronage dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation by a physician. Except as otherwise provided herein, failure to comply with this rule shall result in refusal to file or process that party's application for adjudication or answer. If any of the above parties are not available, cannot be located or are unwilling to sign a declaration under penalty of perjury setting forth in specific detail the reasons that the party is not available, cannot be located or is unwilling to sign as well as good faith efforts to locate the party may be filed with the application or answer. If the presiding workers' compensation judge or designee determines from the facts set forth in the declaration that good cause has been established, he or she may accept the application or answer for filing. For the purpose of this rule, a compromise and release agreement or stipulations with request for award shall not be treated as an application for adjudication.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4906(g), Labor Code.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52). For prior history, see Register 91, No. 7.

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10405. Request for Findings of Fact.

A request for findings of fact under Government Code Sections 21164, 21166, 21537, 21538, 21540, or 21540.5 or under Labor Code Sections 4800.5(d), 4801, 4804.2, 4807 or 4851 is a proceeding separate from a claim for workers' compensation benefits even though it arises out of the same incident, injury or exposure. The request for findings of fact shall be filed separately and a separate file folder and record of the proceeding will be maintained, but the request for findings of fact may be consolidated for hearing with a claim for workers' compensation benefits under the provisions of Section 10590 of these Rules.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 21164, 21166, 21537, 21538, 21540 and 21540.5, Government Code; Sections 4800.5(d), 4801, 4804.2, 4807 and 4851, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10406. Pre-Application and Miscellaneous Proceedings.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 132a, 4553, 4751 and 5401, Labor Code.

HISTORY

1. New section exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

3. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10407. Dismissal of Claim Form--Labor Code Section 5404.5.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5404.5, Labor Code.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Renumbering of former section 10407 to new section 10583 filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10409. Venue.

(a) The person or entity filing an initial Application for Adjudication (or other case opening document) shall designate venue and shall specify whether venue is based upon: (1) the place of the employee or dependent's residence at the time of filing (Lab. Code, § 5501.5(a)(1) or (d)); (2) the place where the injury allegedly occurred or, for cumulative trauma or industrial disease claims, where the last alleged injurious exposure occurred (Lab. Code, § 5501.5(a)(2) or (d)); or (3) the place where the employee's attorney maintains his or her principal place of business (Lab. Code, § 5501.5(a)(3)).

(b) When a Division of Workers' Compensation employee files his or her own Application for Adjudication of Claim or other case opening document, the following provisions shall apply:

(1) Regardless of the venue designated by the employee, venue shall be determined as follows:

(A) The parties may agree on a venue, subject to the approval of the presiding workers' compensation judge of the agreed-upon venue;.

(B) If the parties are unable to agree on a suitable venue, or for any other good cause shown, the presiding workers' compensation judge of the district office designated on the application or other case opening document shall consult with the Secretary or other Deputy Commissioner of the Appeals Board to determine the appropriate venue, with the Secretary or other Deputy Commissioner issuing the appropriate venue order.

(2) The Secretary or other Deputy Commissioner of the Appeals Board shall assign the case to a workers' compensation judge unfamiliar with the employee. When appropriate, a workers' compensation judge from a region other than the employee's region shall be assigned.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5500 and 5501.5, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10408. Forms of Application.

The Application for Adjudication for compensation benefits and death benefits shall be on forms prescribed and approved by the Appeals Board.

Venue shall be at the district office where the Application for Adjudication is filed pursuant to Labor Code Section 5501.5.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5500 and 5501.5, Labor Code.

HISTORY

1. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10410. Objection to Venue Under Labor Code Section 5501.5(c).

Pursuant to Labor Code section 5501.5(c), any employer or insurance carrier listed on an initial Application for Adjudication may file an objection to a venue selection, based on the employee's attorney's principal place of business under Labor Code section 5501.5(a)(3), within 30 days after notice of the adjudication case number and venue is received by the employer or insurance carrier. The objecting employer or insurance carrier shall state under penalty of perjury the date when the notice of the adjudication case number and venue was received.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 5501.5, Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§ 10411. Petition for Change of Venue Under Labor Code Section 5501.6.

A petition for change of venue pursuant to Labor Code section 5501.6 shall be filed at the district office with venue. Any objection to a petition for a change of venue shall be filed within 10 days of the filing of the petition. The presiding judge of the district office having venue, or his or her designee, shall grant or deny the petition for change of venue, or serve notice of a status conference concerning the petition, within 30 days of the filing of the petition.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 5501.6, Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10412. Proceedings and Decisions After Venue Change.

When an order changing venue is issued, all further trial level proceedings shall be conducted at, and all further trial level orders, decisions, and awards shall be issued by, the district office to which venue was changed until another order changing venue is issued.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 126 and 5501.6, Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51). For prior history, see Register 93, No. 52.

2. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10414. Declaration of Readiness to Proceed. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 134, 5502 and 5813, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment of section filed 6-11-92 with Secretary of State by Workers' Compensation Appeals Board; operative 6-11-92. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 92, No. 24).

3. Amendment of first paragraph filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

4. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

5. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10415. Declaration of Readiness to Proceed to Expedited Hearing. [Repealed]

An expedited hearing shall not be placed on calendar unless a party has filed a Declaration of Readiness to Proceed to Expedited Hearing. However, the

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5502(b), Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10416. Objection to Declaration of Readiness to Proceed. [Repealed]

Any objection to a Declaration of Readiness to Proceed shall be filed and served within ten (10) days after service of the Declaration. The objection shall set

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 134 and 5813, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment of first paragraph filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

3. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

4. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10417. Walk-Through Calendar Setting. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5316 and 5502, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

3. Renumbering of former section 10417 to section 10420 and new section 10417 filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

4. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10418. Letters of Appointment for Medical Examinations.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5401 and 5703, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

3. Renumbering of former section 10418 to section 10430 filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10420. Setting the Case.

The Workers' Compensation Appeals Board, upon the receipt of a Declaration of Readiness to Proceed, may, in its discretion, set the case for a type of proceeding other than that requested. The Workers' Compensation Appeals Board may on its own motion set any case for conference or trial.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5310, Labor Code.

HISTORY

1. Renumbering and amendment of former section 10417 to new section 10420 filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10430. Letters of Appointment for Medical Examinations.

After the filing of an Application for Adjudication, each party will notify all other parties, and their attorneys or representatives, of any medical appointment scheduled for the purposes of medical-legal evaluation. That notice shall be given at the same time the injured worker is advised of the appointment.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5401 and 5703, Labor Code.

HISTORY

1. Renumbering and amendment of former section 10418 to new section 10430 filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10440. Pleadings.

SERIOUS WILLFUL MISCONDUCT

All allegations that an injury was caused by either the serious and willful misconduct of the employee or of the employer must be separately pleaded and must set out in sufficient detail the specific basis upon which the charge is founded so that the adverse parties and the Workers' Compensation Appeals Board may be fully advised.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4550, 4551, 4552, 4553, 4553.1, Labor Code.

HISTORY

1. Amendment of section heading filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10445. Allegations.

SERIOUS WILLFUL MISCONDUCT

All allegations that an injury was caused by serious and willful misconduct shall:

(a) When the charge of serious and willful misconduct is based on more than one theory, set forth each theory separately.

(b) Whenever the charge of serious and willful misconduct is predicated upon the violation of a particular safety order, set forth the correct citation or reference and all of the particulars required by Labor Code Section 4553.1.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4550, 4551, 4552, 4553, 4553.1, Labor Code.

HISTORY

1. Repealer of last paragraph filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10447. Pleadings--Discrimination.

Any person seeking to initiate proceedings under Labor Code Section 132a other than prosecution for misdemeanor must file a petition therefor setting forth specifically and in detail the nature of each violation alleged and facts relied on to show the same, and the relief sought. Each alleged violation must be separately pleaded so that the adverse party or parties and the Workers' Compensation Appeals Board may be fully advised of the specific basis upon which the charge is founded.

The Workers' Compensation Appeals Board may refer, or any worker may complain of, suspected violations of the criminal misdemeanor provisions of Labor Code Section 132a to the Division of Labor Standards Enforcement or directly to the Office of the Public Prosecutor.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 132a, Labor Code.

HISTORY

1. Editorial correction filed 2-2-83 (Register 83, No. 6).

2. Amendment of section heading and repealer of second paragraph filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10450. Petitions.

(a) A request for action by the Workers' Compensation Appeals Board, other than an Application for Adjudication, an Answer, or a Declaration of Readiness, shall be made by petition. The caption of each petition shall contain the case title and adjudication case number and shall indicate the type of relief sought.

(b) Any previously filed document shall not be attached to a petition; any such document that is attached to a petition may be discarded.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

2. Amendment of section and Note filed 11-17-2008; operative 11-17-2008.
Submitted to OAL for printing only (Register 2008, No. 47).

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§10452. Petition for Disqualification of Judge.

PETITIONS

Proceedings to disqualify a workers' compensation judge under Labor Code Section 5311 shall be initiated by the filing of a petition for disqualification supported by an affidavit or declaration under penalty of perjury stating in detail facts establishing grounds for disqualification of the workers' compensation judge to whom a case or proceeding has been assigned.

If the workers' compensation judge assigned to hear the matter and the grounds for disqualification are known, the petition for disqualification shall be filed not more than 10 days after service of notice of hearing. In no event shall any such petition be allowed after the swearing of the first witness.

A petition for disqualification shall be referred to and determined by a panel of three commissioners of the Appeals Board in the same manner as a petition for reconsideration.

NOTE: Authority cited: Section 5307, Labor Code. Reference: Sections 5310, 5311, Labor Code.

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§10453. Petition for Automatic Reassignment of Regular Hearing to Another Workers' Compensation Judge.

A party shall be entitled to automatic reassignment of a trial or expedited hearing to another workers' compensation judge in accordance with the provisions of this section. An injured worker shall be entitled to one reassignment of a judge for trial or expedited hearing. If the injured worker has not exercised the right to automatic reassignment and one or more lien claimants have become parties and no testimony has been taken, the lien claimants shall be entitled to one reassignment of judge for a trial, which may be exercised by any of them. The defendants shall be entitled to one reassignment of judge for a trial or expedited hearing, which may be exercised by any of them.

If the parties are first notified of the identity of the workers' compensation judge assigned for trial or expedited hearing by a notice of trial served by mail, to exercise the right to automatic reassignment a party must file a petition requesting reassignment not more than five (5) days after the service of the notice of trial or expedited hearing. The presiding judge or a person designated by the presiding judge shall rule on any petition for automatic reassignment. If a petition for automatic reassignment is granted, a new notice of trial or expedited hearing shall be served.

If the parties are first notified of the identity of the workers' compensation judge assigned for trial at a mandatory settlement conference, at a status conference, at a lien conference, at a priority conference, or upon reassignment at the time of trial, to exercise the right to automatic reassignment a party must make an oral motion immediately upon learning the name of the judge to whom the case has been assigned for trial. The motion shall be acted upon immediately by the presiding workers' compensation judge or a person designated by the presiding judge.

In no event shall any motion or petition for reassignment be entertained after the swearing of the first witness at a trial or expedited hearing.

If a party files a petition or makes a motion for automatic reassignment and no other workers' compensation judge is available in the office, the assignment shall be made by a deputy commissioner of the Appeals Board.

Unless required for the convenience of the Workers' Compensation Appeals Board, no continuance shall be granted by reason of a petition or motion under this section. If a continuance is granted, another trial or expedited hearing shall be scheduled as early as possible.

Consolidated cases are to be considered as one case within the meaning of this section. This section is not applicable to conference hearings.

NOTE

Authority cited: Section 5307, Labor Code. Reference: Section 5310, Labor Code.

HISTORY

1. Editorial correction filed 2-2-83 (Register 83, No. 6).

2. Amendment of section heading, section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10454. Automatic Reassignment After Reversal.

Notwithstanding Rule 10453, where the Appeals Board reverses a decision of a workers' compensation judge on an issue of the statute of limitations, jurisdiction, employment, or injury arising out of and in the course of employment, and remands the case for further proceedings, the party who filed the petition for reconsideration that resulted in the reversal shall be entitled to automatic reassignment of the case to another workers' compensation judge upon a motion or petition requesting reassignment filed at the district office within 30 days after the decision of the Appeals Board becomes final.

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5310, Labor Code.

HISTORY

1. Renumbering of former section 10454 to new section 10455 and new section 10454 filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10458. Petition for New and Further Disability.

PETITIONS

The jurisdiction of the Workers' Compensation Appeals Board under Labor Code Section 5410 shall be invoked by a petition setting forth specifically and in detail the facts relied upon to establish new and further disability.

If no prior Application for Adjudication has been filed, jurisdiction shall be invoked by the filing of an original Application for Adjudication.

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5803, Labor Code.

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§10462. Petition to Terminate Liability; Filing.

A petition to terminate liability for continuing temporary disability indemnity under a findings and award, decision or order of the Appeals Board or a workers' compensation judge shall be filed within 10 days of the termination of the payments or other compensation. Failure to file such a petition within 10 days may affect the right to credit for an overpayment of temporary disability indemnity.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4650, 4651.1, Labor Code.

HISTORY

1. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10464. Contents of Petition to Terminate Liability.

A petition to terminate liability for temporary total disability indemnity shall conform substantially to the form provided by the Appeals Board and shall include:

(a) the correct title and date of filing of the prior order or decision, liability under which is sought to be terminated;

(b) the date upon which it is claimed that liability terminated;

(c) the grounds upon which it is claimed liability should be terminated;

(d) whether permanent disability is being advanced and, if so, the approximate date to which such indemnity will be paid;

(e) whether the employee is presently working, according to information available to the petitioner;

(f) a computer printout showing the dates and the amounts of disability indemnity that have been paid, and the periods covered shall be attached; and

(g) proof of service upon the opposing parties.

All medical reports in the possession of the petitioner that have not previously been served and filed shall accompany the petition. The petition also shall contain a statement, in underlined capital letters, that an order terminating liability for temporary total disability indemnity may issue unless objection thereto is made on behalf of the employee within 14 days after service of the petition.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4650, 4651.1, Labor Code.

HISTORY

1. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10466. Objections to Petition, Hearing, Interim Order.

If written objection to the petition to terminate is not received within fourteen (14) days of its proper filing and service, the Workers' Compensation Appeals Board may order temporary disability compensation terminated, in accordance with the facts as stated in the petition or in such other manner as may appear appropriate on the record. If the petition to terminate is not properly completed or executed in accordance with Section 10464, the Workers' Compensation Appeals Board may summarily deny or dismiss the petition.

Objection to the petition by the employee shall be filed in writing within fourteen (14) days of service of the petition, and shall state the facts in support of the employee's contention that the petition should be denied, and shall be accompanied by a Declaration of Readiness to Proceed to Expedited Hearing. All supporting medical reports shall be attached to the objection. The objection shall also show that service of the objection and the reports attached thereto has been made upon petitioner or counsel.

Upon the filing of a timely objection, where it appears that the employee is not or may not be working and is not or may not be receiving disability indemnity, the petition to terminate shall be set for expedited hearing not less than ten (10) nor more than thirty (30) days from the date of the receipt of the objection.

If complete disposition of the petition to terminate cannot be made at the hearing, the workers' compensation judge assigned thereto, based on the record, including the allegations of the petition, the objection thereto, and the evidence (if any) at said hearing, shall forthwith issue an interim order directing whether temporary disability indemnity shall or shall not continue during the pendency of proceedings on the petition to terminate. Said interim order shall not be considered a final order, and will not preclude a complete adjudication of the petition to terminate or the issue of temporary disability or any other issue after full hearing of the issues.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4650 and 4651.1, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10470. Medical Reports.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5703, 5401, 5270 and 5277, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10480. Answers.

An Answer to each Application for Adjudication shall be filed and served ten (10) days after service of the Declaration of Readiness to Proceed required by rule 10414 or 10415.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5500, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

3. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10484. Procedural Requirement.

The Answer used by the parties shall conform to a form prescribed and approved by the Appeals Board. Additional matters may be pleaded as deemed necessary by the answering party.

A general denial is not an answer within this rule. The Answer shall be accompanied by a proof of service upon the opposing parties.

Evidence upon matters and affirmative defenses not pleaded by Answer will be allowed only upon such terms and conditions as the Appeals Board or workers' compensation judge may impose in the exercise of sound discretion.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5500, 5505, Labor Code.

HISTORY

1. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment of second paragraph filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10488. Form of Answer.

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NOTE: Authority cited: Sections 133, 5307, Labor Code. Reference: Sections 5500, 5505, Labor Code.

HISTORY

1. Repealer filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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§10490. Demurrer, Judgment on the Pleadings, and Summary Judgment Not Permitted; Unintelligible Pleadings.

Demurrers, petitions for judgment on the pleadings, and petitions for summary judgment are not permitted. A continuance may be granted upon timely request and upon such terms as may be reasonable under the circumstances or may be ordered by the Workers' Compensation Appeals Board on its own motion if:

(a) a pleading is so uncertain, unintelligible or ambiguous as to render it impossible for the Workers' Compensation Appeals Board to understand or act upon it; or

(b) any party is prejudiced by omission or ambiguity of necessary allegations sufficient to prevent that party from adequately presenting a cause of action or defense.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5500 and 5708, Labor Code.

HISTORY

1. Amendment of section heading and section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10492. When Pleadings Deemed Amended.

GENERAL

The pleadings shall be deemed amended to conform to the stipulations and statement of issues agreed to by the parties on the record. Pleadings may be amended by the Workers' Compensation Appeals Board to conform to proof.

NOTE: Authority cited: Sections 133, 5307, Labor Code. Reference: Section 5702, Labor Code.

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§10496. Awards and Orders Without Hearing.

GENERAL

Awards and orders may be based upon stipulations of parties in open court or upon written stipulation signed by the parties.

NOTE: Authority cited: Sections 133, 5307, Labor Code. Reference: Section 5702, Labor Code.

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§10497. Rejection of Stipulations.

GENERAL

No finding shall be made contrary to a stipulation of the parties on an issue without giving the parties notice and an opportunity to present evidence thereon.

NOTE: Authority cited: Sections 133, 5307, Labor Code. Reference: Section 5702, Labor Code.

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§ 10500. Service by the Workers' Compensation Appeals Board.

(a) Except as provided in subdivision (b) below, the Workers' Compensation Appeals Board may, in its discretion, designate a party or lien claimant, or their attorney or agent of record, to make service of notices of the time and place of hearing, orders approving compromise and release, awards based upon stipulations with request for award and any interim or procedural orders. In deciding whether to exercise this discretion, the Workers' Compensation Appeals Board may consider whether service by it would be more efficient and cost- effective because most or all of the parties, lien claimants, attorneys, or agents of record to be served have specified e-mail or fax as their preferred method of service. If discretion is exercised so as to require designated service, the party, lien claimant, or attorney or agent of record designated to make service shall retain the proof of service and shall not file it unless ordered to do so by the Workers' Compensation Appeals Board.

(b) The Workers' Compensation Appeals Board shall serve all parties and lien claimants of record notice of any final order, decision, or award issued by it on a disputed issue after submission. The Workers' Compensation Appeals Board shall not designate a party or lien claimant, or their attorney or agent of record, to serve any final order, decision, or award relating to a submitted disputed issue.

(c) If the Workers' Compensation Appeals Board effects personal service of a document at a hearing or at a walk-through proceeding, the proof of personal service shall be made by endorsement on the document, setting forth the fact of personal service, the name(s) of the person(s) served and the date of service. The endorsement shall bear the signature of the person making the service.

(d) If the Workers' Compensation Appeals Board serves a document by mail, the proof of mail service shall be made by endorsement on the document, setting forth the fact of mail service on the persons or entities listed on the official address record who have not designated e-mail or fax as their preferred method of service. The endorsement shall state the date of mail service and it shall bear the signature of the person making the service.

(e) If the Workers' Compensation Appeals Board electronically serves a document through EAMS on persons or entities listed on the official address record who have designated e-mail or fax as their preferred method of service, the record of electronic service maintained in EAMS shall constitute proof of service on such persons or entities by the Workers' Compensation Appeals Board.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5316 and 5504, Labor Code.

HISTORY

1. Repealer and new section exempt from OAL review pursuant to GovernmentCode section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment filed 12-16-92; operative 2-1-93 and exempt from OAL review pursuant to Government Code section 11351 (Register 92, No. 51).

3. Amendment of section and Note filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

4. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

5. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10501. Service in Non-Dependent Death Cases.

When an Application for Adjudication, stipulations with request for award or compromise and release is filed in a death case in which there is a bona fide issue as to partial or total dependency, the filing party shall serve copies of the documents on the Department of Industrial Relations, Death Without Dependents Unit.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 4706.5, Labor Code.

HISTORY

1. Amendment of section heading and section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10505. Service by the Parties or Lien Claimants.

(a) This section shall apply when a document is served by a party, a lien claimant, or their attorney or other agent of record.

(b) Except when a document is personally served, service of any document shall be made by first-class mail or by an alternative method that will effect service that is equivalent to or more expeditious than first-class mail, unless:

(1) the party, lien claimant, attorney, or agent being served has previously specified that a designated preferred method of service other than first-class mail may be used for any service, consistent with section 10218; or

(2) the serving party, lien claimant, attorney, or agent and the receiving party, lien claimant, attorney, or agent previously agreed to some other method of service.

For purposes of this subsection, "an alternative method that will effect service that is equivalent to or more expeditious than first-class mail" shall be limited to either: (i) use of express (overnight) or priority mail; or (ii) use of a bona fide commercial delivery service or attorney service promising delivery within two business days, as shown on the service's invoice or receipt.

(c) If a document is personally served by a party or lien claimant, the proof of personal service shall be made by endorsement on the document, setting forth the fact of personal service, the name(s) of the person(s) served and the date of service. The endorsement shall bear the signature of the person making the service.
(d) If a document is served by a party or lien claimant by mail on persons listed on the official address record who have designated mail as their preferred method of service, who have failed to make any designation, or who have previously agreed to accept mail service in accordance with subdivision (g), the proof of mail service may be made by: (1) affidavit or declaration of service; (2) written statement endorsed upon the document served and signed by the party making the statement; or (3) letter of transmittal. The proof of service shall set forth the names and addresses of persons served, the fact of service by mail, the date of service, and the address(es) to which mailing was made.

(e) If a document is served by a party or lien claimant by e-mail on persons listed on the official address record who have designated e-mail as their preferred method of service, or who have previously agreed to accept e-mail service in accordance with subdivision (g), the proof of e-mail service must state:

(1) the e-mail address of the person making the e-mail service;

(2) the date of the e-mail service;

(3) the name(s) and e-mail address(es) of the person(s) served; and

(4) that the document was served by e-mail and that there was no report of any error or delay in the transmission of the e-mail.

Absent evidence to the contrary, service by e-mail shall be deemed complete at the time of transmission, unless a document is re-served in accordance with subdivision (h).

(f) If a document is served by a party or lien claimant by fax on persons listed on the official address record who have designated fax as their preferred method of service, or who have previously agreed to accept fax service in accordance with subdivision (g), the proof of fax service must state:

(1) the sending fax machine telephone number of the person making the fax service;

(2) the date and time of the fax service;

(3) the name and the fax machine telephone number of the person served; and

(4) that the document was served fax transmission and the transmission was reported as complete and without error.

Absent evidence to the contrary, service by fax shall be deemed complete at the time of transmission, unless a document is re-served in accordance with subdivision (h).

(g) By prior agreement of the parties or lien claimants, or where authorized or requested by the receiving party or lien claimant, service of any document may be made by methods other than the designated preferred method of service.

(h) This subdivision shall apply where, after serving a document in accordance with subdivisions (d), (e), (f), and/or (g), the serving party or lien claimant (or their attorney or agent of record) subsequently receives notification that the service to one or more parties or lien claimants (or to their attorneys or agents of record) failed.

(1) When the serving party or lien claimant (or their attorney or agent of record) receives notification of failed service to any intended recipient(s), the server shall promptly re-serve the document on the intended recipient(s) using the method of service (i.e., mail, e-mail, fax) best calculated to result in valid service on the intended recipient(s), even if the intended recipient(s) did not previously designate that method as their preferred method of service.

(2) The server need not re-serve the document on intended recipients for whom the server did not receive notification of failed service.

(3) On re-service, the server shall execute a new proof of service in accordance with subdivisions (c), (d), (e), and/or (f), showing re-service on the intended recipient(s).

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 5316, Labor Code.

HISTORY

1. Amendment of section heading and text filed 12-23-93; operative 1-1-94.
Submitted to OAL for printing pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

3. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10507. Service: Mailbox.

Where a district office of the Workers' Compensation Appeals Board maintains mailboxes for outgoing documents and allows consenting parties, lien claimants, and attorneys to obtain their documents from their mailboxes, documents so obtained shall be deemed to have been served on the party, lien claimant, or attorney by mail on the date of service specified on the document.

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5316, Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10507. Time Within Which to Act When a Document is Served by Mail, Fax, or E-Mail.

(a) If a document is served by mail, fax, e-mail, or any method other than personal service, the period of time for exercising or performing any right or duty to act or respond shall be extended by:

(1) five calendar days from the date of service, if the physical address of the party, lien claimant, attorney, or other agent of record being served is within California;

(2) ten calendar days from the date of service, if the physical address of the party, lien claimant, attorney, or other agent of record being served is outside of California but within the United States; and

(3) twenty calendar days from the date of service, if the physical address of the party, lien claimant, attorney, or other agent of record being served is outside the United States.

(b) For purposes of this section, "physical address" means the street address or Post Office Box of the party, lien claimant, attorney, or other agent of record being served, as reflected in the Official Address Record at the time of service, even if the method of service actually used was fax, e-mail, or other agreed-upon method of service.

(c) This rule applies whether service is made by the Workers' Compensation Appeals Board, a party, a lien claimant, or an attorney or other agent of record.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 5316, Labor Code.

HISTORY

1. Amendment of section heading and section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

2. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10508. Extension of Time for Weekends and Holidays.

If the last day for exercising or performing any right or duty to act or respond falls on a weekend, or on a holiday for which the offices of the Workers' Compensation Appeals Board are closed, the act or response may be performed or exercised upon the next business day.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 5316, Labor Code; Sections 6700, 6701 and 6707, Government Code; and Sections 10, 12, 12a, 12b, 13 and 135, Code of Civil Procedure.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10510. Service on Represented Employees or Dependents and on Attorneys or Agents.

(a) All orders, decisions, findings, awards, minutes of hearing, notices of hearing, correspondence, and any other documents issued by the Workers' Compensation Appeals Board, including those being served by designated service in accordance with section 10500, shall be served on:

(1) the injured employee or any dependent(s) of a deceased employee, whether or not the employee or dependent is represented by an attorney or other agent of record;

(2) each attorney or other agent of record of the injured employee or any dependent(s) of a deceased employee; and

(3) each attorney or other agent of record for any other affected party or affected lien claimant, unless that party or lien claimant is unrepresented, in which event service shall be made directly on the party or lien claimant.

(b) Except for designated service under section 10500 or as otherwise provided by these rules, service by any party or lien claimant shall be made on the attorney(s) or agent(s) of record of each other affected party or affected lien claimant, unless that party or lien claimant is unrepresented, in which event service shall be made directly on the party or lien claimant. Except as provided in section 10500, or as otherwise ordered by a workers' compensation judge or the Appeals Board, no party or lien claimant shall be required to serve any document on the injured employee or any dependent(s) of a deceased employee, if the employee or dependent is represented by an attorney or other agent of record.

(c) Nothing in this rule shall preclude more comprehensive service, either as ordered by the Workers' Compensation Appeals Board or in the discretion of the Workers' Compensation Appeals Board or the parties.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 5316, Labor Code.

HISTORY

1. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10514. Proof of Service by Parties and Lien Claimants. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5316, Labor Code.

HISTORY

1. Amendment of section heading and text filed 12-23-93; operative 1-1-94.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 93, No. 52).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for
printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

3. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10520. Proof of Service by Workers' Compensation Appeals Board. (Repealed)

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5316, Labor Code.

HISTORY

1. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10530. Subpoenas.

The Workers' Compensation Appeals Board shall issue subpoenas and subpoenas duces tecum upon request in accordance with the provisions of Code of Civil Procedure sections 1985 and 1987.5 and Government Code section 68097.1. Subpoenas and subpoenas duces tecum shall be on forms prescribed and approved by the Appeals Board, and for injuries occurring on or after January 1, 1990, shall contain, in addition to the requirements of Code of Civil Procedure 1985, an affidavit that a claim form has been duly filed pursuant to Labor Code section 5401, subdivision (c).

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 130 and 5401, Labor Code; Sections 1085, 1087.5, Code of Civil Procedure; and Section 68097.1, Government Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

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§10532. Notice to Appear or Produce.

A notice to appear or produce in accordance with Code of Civil Procedure Section 1987 is permissible in proceedings before the Workers' Compensation Appeals Board.

NOTE: Authority cited: Sections 133, 5307, Labor Code. Reference: Section 132, Labor Code.

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§10534. Microfilm.

Where records or other documentary evidence have been recorded or reproduced using the methods described in Section 1551 of the Evidence Code and the original records destroyed, the film, legible print thereof or electronic recording shall be produced in response to a subpoena duces tecum. A party offering a film or electronic recording in evidence may be required to provide legible prints thereof or reproductions from the electronic recording.

The expense of:

(a) inspecting reproductions shall be paid by the party making the inspection; and

(b) obtaining microfilm prints shall be borne by the party requiring the same.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 130, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10536. Witness Fees and Subpoenas.

Medical examiners appointed by the Workers' Compensation Appeals Board or agreed to by the parties when subpoenaed for cross-examination at the Workers' Compensation Appeals Board or deposition shall be paid by the party requiring the attendance of the witness in accordance with the Rules of the Administrative Director.

Failure to serve the subpoena and tender the fee in advance based on the estimated time of the trial or deposition may be treated by the Workers' Compensation Appeals Board as a waiver of the right to examine the witness. Service and payment of the fee may be made by mail if the witness so agrees.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 130, 131, 4621 and 5710, Labor Code; and Section 2034(i)(2), Code of Civil Procedure.

HISTORY

1. Repealer and new section exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10537. Subpoena for Medical Witness.

A subpoena requiring the appearance of a medical witness before the Workers' Compensation Appeals Board must be served not less than ten (10) days before the time the witness is required to appear and testify.

NOTE: Authority cited: Sections 133, 5307, Labor Code. Reference: Section 132, Labor Code.

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§10541. Submission at Conference.

(a) A workers' compensation judge may receive evidence and submit an issue or issues for decision at a conference hearing if the parties so agree.

(b) If documentary evidence is required to determine the issue or issues being submitted, the parties shall comply with the provisions of Rule 10629 regarding the listing and filing of exhibits.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5708 and 5709, Labor Code.

HISTORY

1. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment of section heading, section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Codesection 11351 (Register 2002, No. 51).

3. Amendment of section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10544. Notice of Hearing.

The Workers' Compensation Appeals Board shall serve or cause to be served notice of the time and place of hearings on all parties and lien claimants, and their attorneys or other agents of record, as provided in Rule 10500.

Notice of hearing shall be given at least ten (10) days before the date of hearing, except where:

(a) notice is waived;

(b) a different time is expressly agreed to by all parties and concurred in by the Workers' Compensation Appeals Board; or

(c) the proceedings are governed by Article 19 pertaining to claims against the Subsequent Injuries Fund.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5504, Labor Code.

HISTORY

1. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10548. Continuances; Appearances in Settled Cases. [Repealed].

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Article XIV, Section 4, California Constitution; and Section 5502.5, Labor Code.

HISTORY

1. Amendment of section heading, section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Codesection 11351 (Register 2002, No. 51).

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10550. Proper Identification of the Parties and Lien Claimants.

Whenever any party or lien claimant (or any attorney or other representative for a party or lien claimant) either (i) files any Application for Adjudication, Answer, stipulated Findings and Award, Compromise and Release, lien claim, petition or other pleading with the Workers' Compensation Appeals Board or (ii) states its appearance on the record at any hearing before the Workers' Compensation Appeals Board (including but not limited to stating its appearance on any pretrial conference statement, appearance sheet, or minutes of hearing), the party or lien claimant, or its attorney or other representative, shall comply with the following requirements:

(a) each party or lien claimant shall set forth its full legal name, and each attorney or other representative shall set forth the full legal name(s) of the party or parties he, she, or it is representing;

(b) if an adjusting agent or third-party claims administrator is appearing, it shall disclose: (1) whether it is appearing on behalf of an employer, an insurance carrier, or both; (2) the identity or identities of the party or parties it is representing; and (3) if it is representing an insurance carrier, whether the policy includes a high self-insured retention, a large deductible, or any other provision that affects the identity of the entity or entities actually liable for the payment of compensation;

(c) if an insurance carrier is appearing, it shall disclose: (1) whether it is appearing solely on its behalf, or also on behalf the insured employer; and (2) whether its policy includes a high self-insured retention, a large deductible, or any other provision that affects the identity of the entity actually liable for the payment of compensation; and

(d) if a lien claim is being filed or amended, or if a lien claimant is appearing, the lien claimant shall state whether it is the original owner of the alleged debt or whether it has purchased the alleged debt from the original owner or some subsequent purchaser.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 3755-3759, 4903.1(c), 5001, 5002, 5003, 5004, 5500, 5502, 5503, 5505, 5702 and 5709, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10555. Priority Conference Calendar. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5502(c), Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10560. Submission at Single Trial.

The parties are expected to submit for decision all matters properly in issue at a single trial and to produce at the trial all necessary evidence, including witnesses, documents, medical reports, payroll statements and all other matters considered essential in the proof of a party's claim or defense. However, a workers' compensation judge may order that the issues in a case be bifurcated and tried separately upon a showing of good cause.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Article XIV, Section 4, California Constitution; and Section 5708, Labor Code.

HISTORY

1. Repealer and new section heading and section and amendment of Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10561. Sanctions.

(a) On its own motion or upon the filing of a petition pursuant to Rule 10450, the Workers' Compensation Appeals Board may order payment of reasonable expenses, including attorney's fees and costs and, in addition, sanctions as provided in Labor Code section 5813. Before issuing such an order, the alleged offending party or attorney must be given notice and an opportunity to be heard. In no event shall the Workers' Compensation Appeals Board impose a monetary sanction pursuant to Labor Code section 5813 where the one subject to the sanction acted with reasonable justification or other circumstances make imposition of the sanction unjust.

(b) Bad faith actions or tactics that are frivolous or solely intended to cause unnecessary delay include actions or tactics that result from a willful failure to comply with a statutory or regulatory obligation, that result from a willful intent to disrupt or delay the proceedings of the Workers' Compensation Appeals Board, or that are done for an improper motive or are indisputably without merit. Violations subject to the provisions of Labor Code Section 5813 shall include but are not limited to the following:

(1) Failure to appear or appearing late at a conference or trial where a reasonable excuse is not offered or the offending party has demonstrated a pattern of such conduct.

(2) Filing a pleading, petition or legal document unless there is some reasonable justification for filing the document.

(3) Failure to timely serve documents (including but not limited to medical reports and medical-legal reports) as required by the rules of the Appeals Board, the Court Administrator, or the Administrative Director, where the documents are within the party or lien claimant's possession or control, unless that failure resulted from mistake, inadvertence, or excusable neglect.

(4) Failing to comply with the Workers' Compensation Appeals Board's Rules of Practice and Procedure, with the regulations of the Administrative Director or the Court Administrator, or with any award or order of the Workers' Compensation Appeals Board, including an order of discovery, which is not pending on reconsideration, removal or appellate review and which is not subject to a timely petition for reconsideration, removal, or appellate review, unless that failure results from mistake, inadvertence, surprise, or excusable neglect.

(5) Executing a declaration or verification to any petition, pleading, or other document filed with the Workers' Compensation Appeals Board:

(A) that: (i) contains false or substantially false statements of fact; (ii) contains statements of fact that are substantially misleading; (iii) contains substantial misrepresentations of fact; (iv) contains statements of fact that are made without any reasonable basis or with reckless indifference as to their truth or falsity; (v) contains statements of fact that are literally true, but are intentionally presented in a manner reasonably calculated to deceive; and/or (vi) conceals or substantially conceals material facts; and

(B) where a reasonable excuse is not offered or where the offending party has demonstrated a pattern of such conduct.

(6) Bringing a claim, conducting a defense, or asserting a position:

(A) that is: (i) indisputably without merit, (ii) done solely or primarily for the purpose of harassing or maliciously injuring any person, and/or (iii) done solely or primarily for the purpose of causing unnecessary delay or a needless increase in the cost of litigation; and

(B) where a reasonable excuse is not offered or where the offending party has demonstrated a pattern of such conduct.

(7) Presenting a claim or a defense, or raising an issue or argument, that is not warranted under existing law - unless it can be supported by a nonfrivolous argument for an extension, modification, or reversal of the existing law or for the establishment of new law - and where a reasonable excuse is not offered or where the offending party has demonstrated a pattern of such conduct. In determining whether a claim, defense, issue, or argument is warranted under existing law, or if there is a reasonable excuse for it, consideration shall be given to:

(A) whether there are reasonable ambiguities or conflicts in the existing statutory, regulatory, or case law, taking into consideration the extent to which a litigant has researched the issues and found some support for its theories; and

(B) whether the claim, defense, issue, or argument is reasonably being asserted to preserve it for reconsideration or appellate review.

This subdivision is specifically intended not to have a "chilling effect" on a party or lien claimant's ability to raise and pursue legal arguments that reasonably can be regarded as not settled.

(8) Asserting a position that misstates or substantially misstates the law, and where a reasonable excuse is not offered or where the offending party has demonstrated a pattern of such conduct.

(9) Using any language or gesture at or in connection with any hearing, or using any language in any pleading or other document:

(A) where the language or gesture (i) is directed to the Workers' Compensation Appeals Board, to any of its officials or staff, or to any party or lien claimant (or the attorney or other representative for a party or lien claimant) and (ii) is patently insulting, offensive, insolent, intemperate, foul, vulgar, obscene, abusive, or disrespectful; or

(B) where the language or gesture impugns the integrity of the Workers' Compensation Appeals Board or its Commissioners, judges, or staff.

(e) Notwithstanding any other provision of these rules, for purposes of this rule and Labor Code section 5813: (1) a lien claimant may be deemed a "party" at any stage of the proceedings before the Workers' Compensation Appeals Board; and (2) an "attorney" includes a lay representative of a party or lien claimant.

(f) This rule shall apply only to applications filed on or after January 1, 1994.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 4903.6(c) and 5813, Labor Code.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

3. Amendment of section and Note filed 11-17-2008; operative 11-17-2008.
Submitted to OAL for printing only (Register 2008, No. 47).

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§10562. Failure to Appear.

(a) Where a party served with notice of trial fails to appear either in person or by attorney or representative, the workers' compensation judge may

(1) dismiss the application after issuing a ten (10) day notice of intention to dismiss, or

(2) hear the evidence and, after service of the minutes of hearing and summary of evidence that shall include a ten (10) day notice of intention to submit, make such decision as is just and proper.

(b) Where a party served with notice of a mandatory settlement conference fails to appear at the conference, the workers' compensation judge may

(1) dismiss the application after issuing a ten (10) day notice of intention to dismiss, or

(2) close discovery and forward the case to the presiding workers' compensation judge to set for trial.

(c) Where a party, after notice, fails to appear at either a trial or a conference and good cause is shown for failure to appear, the workers' compensation judge may take the case off calendar or may continue the case to a date certain.

(d) Where a lien claimant served with notice of a conference fails to appear at the conference either in person or by attorney or representative, and fails to have a person with settlement authority available by telephone, the workers' compensation judge may

(1) dismiss the lien claim after issuing a ten (10) day notice of intention to dismiss with or without prejudice, or

(2) close discovery and forward the case to the presiding workers' compensation judge to set for trial.

(e) Where a lien claimant served with notice of a trial fails to appear, the workers' compensation judge may

(1) dismiss the lien claim after issuing a ten (10) day notice of intention to dismiss with or without prejudice, or

(2) hear the evidence and, after service of the minutes of hearing and summary of evidence that shall include a ten (10) day notice of intention to submit, make such decision as is just and proper, or

(3) defer the issue to the lien and submit the case on the remaining issues.

(f) If the workers' compensation judge defers a lien issue, upon the issuance of his or her decision on the remaining issues, the workers' compensation judge shall

(1) issue a ten (10) day notice of intention to order payment of the lien in full or in part, or

(2) issue a ten (10) day notice of intention to disallow the lien, or

(3) continue the lien issue to a lien conference.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Article XIV, Section 4, California Constitution; and Sections 5502(e) and 5708, Labor Code.

HISTORY

1. Repealer and new section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52). For prior history, see Register 91, No. 7.

2. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10563. Appearances Required. (Repealed)

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5502(e) and 5708, Labor Code.

HISTORY

1. Amendment filed 5-25-82; designated effective 7-1-82 (Register 82, No. 22).

2. Amendment exempt from OAL review pursuant to Government Code section11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

3. Editorial correction of History1 (Register 96, No. 52).

4. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

5. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10564. Interpreters.

Subject to the Rules of the Administrative Director, the Workers' Compensation Appeals Board may in any case appoint an interpreter and fix the interpreter's compensation. It shall be the responsibility of any party producing a witness requiring an interpreter to arrange for the presence of a qualified interpreter.

For injuries before January 1, 1994, interpreter's fees that are reasonably, actually and necessarily incurred and that are not allowed under Labor Code Section 4600 shall be allowed as costs under Labor Code Section 5811. Recovery shall be allowed in the amount charged by the interpreter unless:

(1) proof of unreasonableness is entered by the party contesting the reasonableness of the charge, or

(2) the charge is manifestly unreasonable.

For injuries on or after January 1, 1994, interpreter's fees that are reasonably, actually and necessarily incurred shall be allowed as provided by Labor Code Sections 4600, 5710 and 5811 as amended July 16, 1993. Interpreter's fees as defined in Labor Code section 4620, that are reasonably, actually and necessarily incurred as provided in Labor Code section 4621, shall be allowed in accordance with the fee schedule set by the Administrative Director.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4600, 4621, 5710 and 5811, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10566. Minutes of Hearing and Summary of Evidence.

Minutes of hearing and summary of evidence shall be prepared at the conclusion of each hearing and filed in the record of proceedings. They shall include:

(a) The names of the commissioners, deputy commissioner or workers' compensation judge, reporter, the parties present, attorneys or other agents appearing therefor and witnesses sworn;

(b) The place and date of said hearing;

(c) All interlocutory orders, admissions and stipulations, the issues and matters in controversy, a descriptive listing of all exhibits received for identification or in evidence (with the identity of the party offering the same) and the disposition, which shall include the time and action, if any, required for submission;

(d) A summary of the evidence required by Labor Code Section 5313 that shall include a fair and unbiased summary of the testimony given by each witness;

(e) If motion pictures are shown, a brief summary of their contents;

(f) A fair statement of any offers of proof.

If the disposition is an order taking off calendar or a continuance, the reason therefor shall be given.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5313, Labor Code.

HISTORY

1. Amendment of subsection (d) filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10570. Minute Orders.

Interlocutory or interim orders, including dismissal of improper or unnecessary parties, may be entered upon the minutes of hearing and will become the order of the Workers' Compensation Appeals Board upon the filing thereof.

NOTE: Authority cited: Sections 133, 5307, Labor Code. Reference: Section 5307.5, Labor Code.

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§10578. Waiver of Summary of Evidence.

The summary of evidence need not be filed upon waiver by the parties or upon issuance of a stipulated order, decision or award.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5702, Labor Code.

HISTORY

1. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10580. Evidence Taken Without Notice.

Transcripts or summaries of testimony taken without notice and copies of all reports and other matters added to the record, otherwise than during the course of an open hearing, shall be served upon the parties to the proceeding. Unless it is otherwise expressly provided, the parties shall be allowed 10 days after service of the testimony and reports within which to produce evidence in explanation or rebuttal or to request further proceedings before the case shall be deemed submitted for decision.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5704, Labor Code.

HISTORY

1. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10582. Inactive Cases, Procedure, Subsequent Action.

This rule applies to injuries occurring before January 1, 1990 and on or after January 1, 1994.

An Application for Adjudication filed without an accompanying Declaration of Readiness to Proceed will be placed in inactive status.

Cases set for hearing may be removed from the active calendar by an order taking off calendar.

Cases in off calendar status may be restored to the active calendar upon the filing and serving of a properly executed Declaration of Readiness to Proceed.

Unless a case is activated for hearing within one year after the filing of the Application for Adjudication or the entry of an order taking off calendar, the case may be dismissed after notice and opportunity to be heard. Such dismissals may be entered at the request of an interested party or upon the Workers' Compensation Appeals Board's own motion for lack of prosecution. A case may be dismissed after issuance of a ten (10) day notice of intention to dismiss and an opportunity to be heard, but not by an order with a clause rendering the order null and void if an objection showing good cause is filed.

A petition by a defendant to dismiss the case must be accompanied by a copy of a letter mailed to the applicant and, if represented, to the applicant's attorney or representative, more than thirty (30) days before the filing of the petition to dismiss. This letter must state that it is the intention of the persons signing the letter to file a petition for dismissal thirty (30) days after the date of that letter unless the applicant or his attorney or representative shows in writing some good reason for not dismissing the case. A copy of the reply, if any, must be attached to the petition to dismiss. A copy of the petition must be served on all parties and all lien claimants.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5405 and 5406, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment of first paragraph filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

3. Amendment of second and third paragraphs and amendment of Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10583. Dismissal of Claim Form -Labor Code Section 5404.5.

Where an application for adjudication for an injury on or after January 1, 1990 and before January 1, 1994, has not been filed by any of the parties, an employer or insurer seeking dismissal of a claim form for lack of prosecution shall solely utilize the procedures set forth in Labor Code Section 5404.5 and shall not seek an order of dismissal from the Appeals Board by the filing of an application for adjudication, a request for pre-application determination or any other petition or request.

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5404.5, Labor Code.

HISTORY

1. Renumbering of former section 10407 to new section 10583 filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51)

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§10589. Consolidation of Cases.

(a) Consolidation of two or more related cases, involving either the same injured employee or multiple injured employees, rests in the sound discretion of the Workers' Compensation Appeals Board. In exercising that discretion, the Workers' Compensation Appeals Board shall take into consideration any relevant factors, including but not limited to the following:

(1) whether there are common issues of fact or law;

(2) the complexity of the issues involved;

(3) the potential prejudice to any party, including but not limited to whether granting consolidation would significantly delay the trial of any of the cases involved;

(4) the avoidance of duplicate or inconsistent orders; and

(5) the efficient utilization of judicial resources.

Consolidation may be ordered for limited purposes or for all purposes.

(b) Consolidation may be ordered by the Workers' Compensation Appeals Board on its own motion, or may be ordered based upon a petition filed by one of the parties. A petition to consolidate shall:

(1) List all named parties in each case;

(2) Contain the adjudication case numbers of all the cases sought to be consolidated, with the lowest numbered case shown first;

(3) Be filed in each case sought to be consolidated; and

(4) Be served on all attorneys or other representatives of record and on all non-represented parties in each case sought to be consolidated.

(c) Any order regarding consolidation shall be filed in each case to which the order relates.

(d) If consolidation is ordered, the Workers' Compensation Appeals Board, in its discretion, may designate one case as the master file for exhibits and pleadings. If a master file is designated, any subsequent exhibits and pleadings filed by the parties and lien claimants during the period of consolidation shall be filed only in the master case, however, all pleadings and exhibit cover sheets filed shall include the caption and case number of the master file case, followed by the case numbers of all of the other consolidated cases.

(e) If a master file has been designated and the consolidated cases are tried, all relevant documentary evidence previously received in an individual case shall be deemed admitted in evidence in the consolidated proceedings under the master file and shall be deemed part of the record of each of the several consolidated cases. Evidence received subsequent to the designation of the master file shall be similarly received with like force and effect.

(f) When cases are consolidated, joint minutes of hearing, summaries of evidence, opinions, decisions, orders, findings, or awards may be used, however, copies shall be filed in the record of proceedings of each case.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5300, 5301, 5303 and 5708, Labor Code.

HISTORY

1. Renumbering of former section 10590 to new section 10589, including amendment of section and Note, filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

Amendment of section heading, section and Note filed 11-17-2008; operative11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10590. Consolidated Cases-Same Injured Worker. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5303, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Renumbering of former section 10590 to new section 10589 and new section 10590 filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

3. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10591. Consolidating Cases-Multiple Injured Workers. (Repealed)

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5303 and 5313, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10592. Pleadings in Consolidated Cases. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5303 and 5313, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10593. Testimony of Judicial or Quasi-Judicial Officers of the Workers' Compensation Appeals Board or of the Division of Workers' Compensation.

(a) No judicial or quasi-judicial officer of the Workers' Compensation Appeals Board or of the Division of Workers' Compensation may be subpoenaed or ordered to testify regarding either (1) the reasons for or basis of any decision or ruling he or she has made or (2) his or her opinion regarding any statements, conduct, or events occurring in proceedings before him or her, except as follows:

(A) The judicial or quasi-judicial officer may be ordered to testify where his or her testimony is necessary on an issue of disqualification under Labor Code section 5311 and Code of Civil Procedure section 641.

(B) The judicial or quasi-judicial officer may be ordered to testify where his or her testimony is necessary on an issue of an alleged ex parte communication.

The judicial or quasi-judicial officer may be subpoenaed or ordered to testify as a percipient witness to statements, conduct, or events that occurred in the proceedings before him or her, to the same extent as any other percipient witness.

(b) The testimony of a judicial or quasi-judicial offer shall be given only on the terms and conditions ordered by the presiding workers' compensation judge of the district office having venue, or by the Appeals Board, after the filing of a "Petition to Compel the Testimony of a Judicial or Quasi-Judicial Officer."

(1) The petition to compel shall set forth with specificity the facts (or alleged facts) and law that support the petition.

(2) The petition to compel shall be verified under penalty of perjury.

(3) The petition to compel shall be served on all other parties, on all lien claimants whose liens are presently pending in issue in the underlying claim to which the petition relates, and on the Legal Unit of the Division of Workers' Compensation (DWC-Legal Unit), together with a proof of service. [As of the effective date of this rule, the street address of the DWC-Legal Unit is 1515 Clay Street, 18th Floor, Oakland, CA 94612-1402 and the Post Office Box of the DWC-Legal Unit is P.O. Box 420603, San Francisco, CA 94142. However, current information regarding the street address and Post Office Box of the DWC-Legal Unit may be obtained by calling the Headquarters of the Division of Workers' Compensation, whose number, as of the effective date of this rule, is

(510) 286-7100.]

(4) A petition to compel that does not meet all of the foregoing requirements may be summarily dismissed or denied.

(c) The other parties, lien claimants, and the DWC-Legal Unit shall have 15 days within which to file any objection to the petition to compel.

(d) The petition to compel shall be determined: (1) by the presiding workers' compensation judge of the district office having venue; (2) by a Deputy Commissioner of the Appeals Board, if the petition to compel relates to the presiding workers' compensation judge of the district office having venue; or (3) by the Appeals Board, if the petition to compel relates to a pending or impending petition for reconsideration, removal or disqualification,. The petition may be determined on the pleadings submitted or, in the discretion of the presiding workers' compensation judge or the Appeals Board, the petition may be set for a hearing.

(e) In determining whether to grant the petition to compel (and, if granted, in determining the terms and conditions upon which the testimony of the judicial or quasi-judicial officer may be given), the presiding workers' compensation judge or the Appeals Board may consider, among other things:

(1) Whether the testimony of the judicial or quasi-judicial officer is reasonably necessary, taking into consideration (A) whether statements in the judicial or quasi-judicial officer's opinion on decision, report on reconsideration, removal, or disqualification, or other similar statements are sufficient to resolve any allegation by a party or lien claimant; and (B) if not, whether the judicial or quasi-judicial officer's factual statements may be fairly provided by an affidavit or declaration under penalty of perjury.

(2) Whether the testimony of the judicial or quasi-judicial officer under the "percipient witness" exception would be cumulative to the testimony of other percipient witnesses.

(f) For purposes of this section, the term "judicial or quasi-judicial officer of the Workers' Compensation Appeals Board or of the Division of Workers' Compensation" shall include, but shall not be limited to: (1) any Commissioner; (2) any Deputy Commissioner; (3) any presiding workers' compensation judge or workers' compensation judge; (4) any pro tempore workers' compensation judge; (5) any special master appointed by the Workers' Compensation Appeals Board; (6) the Administrative Director and his or her designee; (7) the Court Administrator and his or her designee; (8) any workers' compensation consultant of the Rehabilitation Unit or of the Retraining and Return to Work Unit; and (9) any arbitrator or mediator.

(g) For purposes of this section, the term "testify" shall include testimony in either oral or written form (e.g., affidavits, declarations, interrogatories) and shall include all testimony, whether given at a deposition or a hearing.

(h) This section shall apply solely to testimony sought in connection with a matter within the jurisdiction of the Workers' Compensation Appeals Board, and it shall not apply to testimony sought pursuant to the authority of any other forum.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5300, 5301, 5309, 5700, 5701 and 5708, Labor Code; and Section 703.5, Evidence Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10600. Evidence and Reports.

The filing of a document does not signify its receipt in evidence, and, except for the documents listed in section 10750 of these Rules, only those documents that have been received in evidence shall be included in the record of proceedings on the case.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5708, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10601. Copies of Non-Medical Reports and Records.

Where documents, including videotapes, are to be offered into evidence, copies shall be served on all adverse parties no later than the mandatory settlement conference, unless a satisfactory showing is made that the documents were not available for service by that time.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5502(e), Labor Code.

HISTORY

1. Amendment of section heading, section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10602. Permanent Disability Evaluation Reports.

The Workers' Compensation Appeals Board may request the Disability Evaluation Unit to prepare a formal rating determination on a form prescribed for that purpose by the Administrative Director. The request may refer to an accompanying medical report or chart for the sole purpose of describing measurable physical elements of the condition that are clearly and exactly identifiable. In every instance the request shall describe the factors of disability in full.

The report of the Disability Evaluation Unit in response to the request shall constitute evidence only as to the percentage of the permanent disability based on the factors described, and the report shall not constitute evidence as to the existence of the permanent disability described.

The report of the Disability Evaluation Unit shall be filed and served on the parties and shall include or be accompanied by a notice that the case shall be submitted for decision seven (7) days after service unless written objection is made within that time.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4660 and 5708, Labor Code.

HISTORY

1. Amendment of section heading, section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10603. Oversized Exhibits, Diagnostic Imaging, Physical Exhibits, and Exhibits on Media.

(a) The following exhibits shall be filed only at the time of trial:

(1) Oversized documents, other than medical reports, that are: (A) larger than 11 x 17 inches (e.g., maps, diagrams, and schematic drawings) or (B) over 25 pages in length;

(2) Diagnostic imaging, including but not limited to any X-ray, computed axial tomography (CAT) scan, magnetic resonance imaging (MRI), nuclear medicine, positron emission tomography (PET) scan, mammography, ultrasound, or other similar medical imaging that is stored on digital, film, or other non-paper media;

(3) Original business or office records;

(4) Physical objects or other tangible things;

(5) Any CD-ROM, DVD, or other digital media, including but not limited to: (A) digital photographs; (B) digital video recordings; and (C) digital audio recordings;

(6) Videotapes, audiotapes, films and other non-digital video and/or audio recordings or images; and

(7) Photographs printed on paper.

(b) Unless otherwise ordered by the Workers' Compensation Appeals Board, any exhibit listed in subdivision (a) that is offered into evidence (whether or not admitted into evidence) shall be retained by the filing party (or an agent of the filing party) until the later of either: (1) five years after the filing of the initial application for adjudication (or other case opening document) or (2) at least six months after all appeals have been exhausted or the time for seeking appellate review has expired with respect to the decision on the issue(s) for which the exhibit was offered in evidence. After expiration of the later of these two time periods, the party may destroy the exhibit, unless the Workers' Compensation Appeals Board has ordered that the exhibit be preserved for a longer period.

(c) Before and during the period of retention, the filing party shall:

(1) Maintain the exhibit under conditions that will protect it against loss, destruction, or tampering, and that will preserve its quality and integrity as far as practicable;

(2) At the request of any other party to the action, promptly permit the party to inspect or view the exhibit; and

(3) At the request of any other party to the action, and if practicable, promptly furnish the party a copy of the exhibit or promptly permit the party to make a copy.

For purposes of subsection (c), the term "exhibit" shall include any item listed in subsection (a), whether or not the party or lien claimant in possession or control of that item intends to offer it in evidence.

(d) Any disputes regarding subdivision (c), including but not limited to issues of timing and costs, may be submitted for determination to the Workers' Compensation Appeals Board.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5309, 5701, 5703, 5704 and 5708, Labor Code

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10604. Certified Copies.

Certified copies of the reports or records of any governmental agency, division or bureau shall be admissible in evidence in lieu of the original reports or records.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5703 and 5708, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10605. Reproductions of Documents.

A nonerasable optical image reproduction provided that additions, deletions, or changes to the original document are not permitted by the technology, a photostatic, microfilm, microcard, miniature photographic, or other photographic copy or reproduction, or an enlargement thereof, of a writing is admissible as the writing itself if the copy or reproduction was made and preserved as a part of the records of a business (as defined by Evidence Code Section 1270) in the regular course of that business. The introduction of the copy, reproduction, or enlargement does not preclude admission of the original writing if it is still in existence. The Workers' Compensation Appeals Board may require the introduction of a hard copy printout of the document.

A printed representation of images stored on a video or digital medium is presumed to be an accurate representation of the images it purports to represent. This presumption is a presumption affecting the burden of producing evidence. If a party to an action introduces evidence that a printed representation of images stored on a video or digital medium is inaccurate or unreliable, the party introducing the printed representation into evidence has the burden of proving by a preponderance of the evidence, that the printed representation is an accurate representation of the existence and content of the images that it purports to represent.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5708, Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10606. Physicians' Reports as Evidence.

The Workers' Compensation Appeals Board favors the production of medical evidence in the form of written reports. Direct examination of a medical witness will not be received at a trial except upon a showing of good cause. A continuance may be granted for rebuttal testimony subject to Labor Code Section 5502.5.

These reports should include where applicable:

(a) the date of the examination;

(b) the history of the injury;

(c) the patient's complaints;

(d) a listing of all information received from the parties reviewed in preparation of the report or relied upon for the formulation of the physician's opinion;

(e) the patient's medical history, including injuries and conditions, and residuals thereof, if any;

(f) findings on examination;

(g) a diagnosis;

(h) opinion as to the nature, extent, and duration of disability and work limitations, if any;

(i) cause of the disability;

(j) treatment indicated;

(k) opinion as to whether or not permanent disability has resulted from the injury and whether or not it is stationary. If stationary, a description of the disability with a complete evaluation;

(l) apportionment of disability, if any;

(m) a determination of the percent of the total causation resulting from actual events of employment, if the injury is alleged to be a psychiatric injury;

(n) the reasons for the opinion; and,

(o) the signature of the physician.

Failure to comply with (a) through (o) will be considered in weighing the evidence.

In death cases, the reports of non-examining physicians may be admitted into evidence in lieu of oral testimony.

All medical-legal reports shall comply with the provisions of Labor Code Section 4628. Except as otherwise provided by the Labor Code, including Labor Code Sections 4628 and 5703, and the rules of practice and procedure of the Appeals Board, failure to comply with the requirements of this section will not make the report inadmissible but will be considered in weighing the evidence.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4603.2, 4628, 5703, 5708 and 5709, Labor Code.

HISTORY

1. New subsections (i), (j) and (k) filed 5-25-82; designated effective 7-1-82 (Register 82, No. 22).

2. Editorial correction of subsection (h) filed 2-2-83 (Register 83, No. 6).

3. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

4. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10607. Computer Printouts of Benefits Paid.

If a party requests that a defendant provide a computer printout of benefits paid, within twenty (20) days the defendant shall provide the requesting party with a current computer printout of benefits paid. The printout shall include the date and amount of each payment of temporary disability indemnity, permanent disability indemnity, and vocational rehabilitation maintenance allowance, and the period covered by each payment, and the date, payee, and amount of each payment for medical treatment. This request may not be made more frequently than once in a one-hundred-twenty (120) day period unless there is a change in indemnity payments.

A defendant that has paid benefits shall have a current computer printout of benefits paid available for inspection at every mandatory settlement conference.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5502(e) and 5708, Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10608. Physicians' Reports.

(a) After the filing of an Application for Adjudication, if a party is requested by another party or lien claimant to serve copies of physicians' reports relating to the claim, the party receiving the request shall serve copies of the reports on the requesting party or lien claimant within six (6) days of the request; the party receiving the request shall serve a copy of any subsequently-received physician's report within six (6) days of receipt of the report.

(b) A Declaration of Readiness to Proceed, a Declaration of Readiness to Proceed to Expedited Hearing, or an objection to either shall be accompanied by the physicians' reports that are in the possession or under control of the declarant. At the time of filing, it shall be the duty of the declarant to serve copies of physicians' reports that have not been previously served and that are in the possession or under the control of the declarant on all other parties and all lien claimants requesting service.

(c) Within six (6) days after service of the Declaration of Readiness to Proceed or Declaration of Readiness to Proceed to Expedited Hearing, all other parties and lien claimants shall serve upon the opposing parties copies of all reports of physicians that are in their possession or under their control, and that have not been previously served. All reports that have not been previously filed, and whose filing is not required by subsection (b), shall be filed at the next hearing.

(d) All physicians' reports that have not been previously filed shall be filed upon the filing of a compromise and release or stipulations with request for award.

(e) Any report filed in violation of this section may be discarded by the Workers' Compensation Appeals Board.

(f) X-rays shall not be transmitted to the Workers' Compensation Appeals Board except under a specific order directing their production.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5001, 5502, 5703 and 5708, Labor Code.

HISTORY

1. Repealer and new section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment of section heading, section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10609. Service on Lien Claimants.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4903.1, 5708 and 5709, Labor Code.

HISTORY

1. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10610. Cross-Examination of Physicians.

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Article XIV, Section 4, California Constitution; Sections 4621 and 5709, Labor Code.

HISTORY

1. Amendment of Note filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10615. Continuing Duty to Serve.

During the continuing jurisdiction of the Workers' Compensation Appeals Board, the parties have a continuing duty to serve on each other and any lien claimant requesting service any physicians' reports received.

NOTE

Authority cited: Sections 133 and 5307, Labor Code.

HISTORY

1. Repealer and new section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Editorial correction of first sentence (Register 96, No. 5).

3. Amendment of section heading, repealer and new section and new Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10616. Employer-Maintained Medical Records.

A written communication from a physician containing any information listed in Section 10606 that is contained in any record maintained by the employer in the employer's capacity as employer will be deemed to be a physician's report and shall be served as required in Sections 10608 and 10615. Records from an employee assistance program are not required to be filed or served unless ordered by the Workers' Compensation Appeals Board.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 4600, 5703 and 5708, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

2. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10618. X-Rays.

On order of the Appeals Board or workers' compensation judge, a party shall forthwith transmit all X-rays to the person designated in the order.

X-rays shall be subpoenaed only when they are relevant to pending issues and there is a present and bona fide intent to offer them in evidence. X-rays produced in violation of this rule will be ordered returned to their original custodian at the expense of the party causing them to be produced.

Upon reasonable request of a party, X-rays in the possession of, or subject to the control of, an adverse party or lien claimant shall be made available for examination by the requesting party or persons designated by that party at a time or place convenient to the persons to make the examination.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4600 and 5708, Labor Code.

HISTORY

1. Amendment of section heading, section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10619. Subpoena of X-Rays.

NOTE

Authority cited: Sections 133, 5307, 5708 and 5709, Labor Code. Reference: Sections 4600, 5708 and 5709, Labor Code.

HISTORY

1. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10620. Examination of X-Rays.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4600, 5708 and 5709, Labor Code.

HISTORY

1. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10622. Failure to Comply.

Disclosure, service and filing of all medical reports in the possession and control of every party to a proceeding, except as otherwise expressly provided, is essential to and required in the expeditious determination of controversies.

The Workers' Compensation Appeals Board may decline to receive in evidence, either at or subsequent to hearing, any report offered under the provisions of Labor Code Section 5703 by a party who has failed to comply with the provisions of Rules 10600, 10608, 10615, 10616 or 10618. A medical report shall not be refused admission into evidence at a hearing, solely upon the ground of a late filing, where examination was diligently sought and said report came into possession or control of the party offering it within the preceding seven (7) days.

Where a willful suppression of a medical report is shown to exist in violation of these rules, it shall be presumed that the findings, conclusions and opinions therein contained would be adverse, if produced.

The remedies in this section are cumulative to all others authorized by law.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5708, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10626. Examining and Copying Hospital and Physicians' Records.

Subject to Labor Code section 3762, and except as otherwise provided by law, all parties, their attorneys, agents and physicians shall be entitled to examine and make copies of all or any part of physician, hospital, or dispensary records that are relevant to the claims made and the issues pending in a proceeding before the Workers' Compensation Appeals Board.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 4600, Labor Code.

HISTORY

1. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10629. Filing and Listing of Exhibits.

(a) Proposed exhibits shall be filed in accordance with the provisions of section 10233 and 10603.

(b) At every mandatory settlement conference, regular hearing, expedited hearing, and conference at which any issue will be submitted for decision, each party or lien claimant shall submit, and shall personally serve on each other appearing party or appearing lien claimant, a list of the exhibits that the party or lien claimant proposes to offer in evidence.

(1) If any such hearing is continued, a new list identifying all of the party or lien claimant's proposed exhibits (including all previously listed exhibits that the party or lien claimant still intends to offer, and any new exhibits) shall be prepared and served, with the exceptions that: (A) any exhibit already admitted in evidence, or marked in evidence but not admitted, need not be re-listed; (B) if the previous list was accepted for filing and scanned into EAMS, and no changes have been made to the previous list, a new list need not be prepared and served; and (C) if the previous list was served (but not accepted for filing and scanned into EAMS), and no changes have been made to the previous list, a new list need not be served, but the list still must be filed.

(2) If a list of exhibits is being submitted after an initial mandatory settlement conference, the list shall separately identify:

(A) the exhibits that the party listed at the time of the initial mandatory settlement conference; and

(B) the exhibits that the party did not list at the time of the initial mandatory settlement conference.

(c) If a party or lien claimant with a currently pending issue fails to appear after proper notice at any hearing described in subdivision (b), even if the party or lien claimant was excused from appearing, then:

(1) the non-appearing party or lien claimant with a currently pending issue shall forthwith file and serve its exhibit list, but consideration of its exhibits shall be subject to the limitations or evidentiary sanctions set forth in section 10562; and

(2) the appearing party(ies) or lien claimant(s) shall forthwith serve their exhibit list(s) on the non-appearing party or lien claimant.

For purposes of this subdivision, a party or lien claimant will be deemed to have a “currently pending issue” if an issue directly related to that party or lien claimant has been raised in a declaration of readiness and that issue has not been resolved by a stipulation or adjudication, it has not been withdrawn (including by failure to raise the issue at the

mandatory settlement conference or trial), and it has not been judicially deferred.

(d) Each exhibit listed must be clearly identified by author/provider, date, and title or type (e.g., “the July 1, 2008 medical report of John Doe, M.D. (3 pages)”). Each medical report, medical-legal report, medical record, or other paper or record having a different author/provider and/or a different date is a separate “document” and must be listed as a separate exhibit, with the exception that the following documents may be listed as a single exhibit, unless otherwise ordered by the Workers' Compensation Appeals Board:

(1) excerpted portions of physician, hospital or dispensary records, provided that the party offering the exhibit designates each excerpted portion by the title of the record or document, by the date or dates of treatment or other service(s) covered by the record or document, by the author or authors of the record or document, and by any available page number(s) (e.g., Bates-numbered pages of records or documents photocopied and numbered by a legal copy service). Only the relevant excerpts of physician, hospital or dispensary records shall be admitted in evidence;

(2) excerpted portions of personnel records, wage records and statements, job descriptions, and other business records provided that the party offering the exhibit designates each excerpted portion by the title of the record or document, by the date or dates covered by the record or document, by the author or authors of the record or document, and by any available page number(s) (e.g., Bates-numbered pages of records or documents photocopied and numbered by a legal copy service). Only the relevant excerpts of personnel records, wage records and statements, job descriptions, and other business records shall be admitted in evidence; and

(3) Explanation of Benefits (EOB) letters.

(e) Each exhibit listed must specify an exhibit number or initial that identifies it and the party, parties, or lien claimant offering it (e.g., Applicant's Exhibit 1, 2, 3, etc.; Defendant's Exhibit A, B, C, etc.; Lien Claimant's AA, BB, CC, etc.; Joint Exhibit XX, YY, etc.).

(f) Nothing in this section shall prevent a workers' compensation judge from referring an unrepresented injured employee, dependent or uninsured employer to the Information and Assistance Office to prepare an exhibit list in accordance with the provisions of subdivisions (a), (b), (c), (d) and (e).

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5309 and 5708, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10630. Return of Exhibits. (Repealed)

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. Amendment of last paragraph filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10631. Specific Finding of Fact--Labor Code Section 139.2(d)(2).

Where a qualified medical evaluator's report has been considered and rejected pursuant to Labor Code section 139.2, subdivision (d)(2), the workers' compensation judge or Appeals Board shall make and serve a specific finding on the qualified medical evaluator and the Industrial Medical Council at the time of decision on the regular workers' compensation issues. The specific finding may be included in the decision.

If the Appeals Board, on reconsideration, affirms or sets aside the specific finding of fact filed by a workers' compensation judge, it shall advise the qualified medical evaluator and the Industrial Medical Council at the time of service of its decision on the petition for reconsideration. If the workers' compensation judge does not make a specific finding and the Appeals Board, on reconsideration, makes a specific finding of rejection pursuant to Labor Code Section 139.2, subdivision (d)(2), it shall serve its specific finding on the qualified medical evaluator and the Industrial Medical Council at the time it serves its decision after reconsideration.

Rejection of a qualified medical evaluator's report pursuant to Labor Code section 139.2, subdivision (d)(2) shall occur where the qualified medical evaluator's report does not meet the minimum standards prescribed by the provisions of Rule 10606 and the regulations of the Industrial Medical Council.

This rule shall apply to injuries on or after January 1, 1994.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 139.2(d)(2), Labor Code.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment of first paragraph filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10632. Labor Code Section 4065--Evidence.

Where the provisions of Labor Code Section 4065 apply, the workers' compensation judge shall receive into evidence the “proposed ratings” submitted by the parties.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 4065, Labor Code.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10633. Proposed Rating-Labor Code Section 4065.

A “proposed rating” pursuant to Labor Code Section 4065 shall include the appropriate disability numbers for each part of the body resulting in permanent disability and a standard rating of the factors of disability.

Where the provisions of Labor Code Section 4065 have been used to determine permanent disability, the workers' compensation judge shall comply with Labor Code Section 5313 and state the evidence relied upon and the reasons or grounds on which selection of the proposed rating is based.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 4065, Labor Code.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment of first paragraph filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10634. Labor Code Section 4628(k) Requests.

Failure to comply with Labor Code Section 4628, subdivision (k) shall not make the medical report inadmissible as evidence and eliminate liability for medical-legal costs where good cause has been shown for the failure to comply and, after notice of non-compliance, compliance takes place within a reasonable period of time or within a time prescribed by the workers' compensation judge.

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 4628(k), Labor Code.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10635. Reasonable Value of Medical Service. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4600, 4624 and 4625, Labor Code.

HISTORY

1. Repealer exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

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New query

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§10700. Impartial Medical Examiners.

NOTE

Authority cited: Sections 133 and 5703, Labor Code. Reference: Sections 139.1 and 5703.5, Labor Code.

HISTORY

1. Repealer and new section exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10705. Policy. (Repealed)

NOTE: Authority cited: Sections 133, 5307, Labor Code. Reference: Article XIV, Section 4, California Constitution.

HISTORY

1. Repealer filed 10-21-96; operative 11-1-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 43).

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New query

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§10715. Orders Directing Applicants to Report for Medical Examination.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 139, Labor Code.

HISTORY

1. Editorial correction filed 2-2-83 (Register 83, No. 6).

2. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10718. Prohibited Communication.

All correspondence concerning the examination and reports of a physician appointed pursuant to Labor Code Section 5701 or 5703.5 shall be made through the Workers' Compensation Appeals Board, and no party, attorney or representative shall communicate with that physician with respect to the merits of the case unless ordered to do so by the Workers' Compensation Appeals Board.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5701 and 5703.5, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10722. Filing and Service of Medical Reports.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 139, 5703.5, 5708, Labor Code.

HISTORY

1. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10727. Cross-Examination by Deposition.

The Workers' Compensation Appeals Board favors cross-examination of medical witnesses by way of deposition. Reasonable costs in connection with such deposition shall be allowed under Labor Code Section 4621.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Article XIV, Section 4, California Constitution; and Section 5708, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10740. Transcripts.

Unless otherwise ordered by a commissioner, a deputy commissioner, or a presiding workers' compensation judge, testimony taken at hearings in compensation proceedings will not be transcribed except upon the request of a party accompanied by the fee prescribed in the Rules of the Administrative Director.

Requests for transcription of testimony shall be in writing, served on all other parties, directed to the transcript clerk and accompanied by a deposit fee based on the transcript clerk's estimate of the number of pages to be transcribed. If the actual fee exceeds the deposit, the purchaser shall pay the balance of the fee before the transcript is released. Any excess deposit will be returned to the purchaser.

No person shall make a photographic copy of a transcript from the Board file except upon payment prescribed by law for a copy of the transcript.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 127 and 5708, Labor Code.

HISTORY

1. Amendment of first paragraph filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10750. Record of Proceedings.

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a) The Workers' Compensation Appeals Board's record of proceedings consists of: the pleadings, declarations of readiness to proceed, minutes of hearing and summary of evidence, transcripts, if prepared and filed, proofs of service, evidence received in the course of a hearing, exhibits marked but not received in evidence, notices, petitions, briefs, findings, orders, decisions and awards, and the arbitrator's file, if any. Each of these documents are part of the record of proceedings, whether maintained in paper or electronic form. Documents that are in the adjudication file but have not been received or offered in evidence are not part of the record of proceedings.

(b) Upon approval of a compromise and release or stipulations with request for award, all medical reports that have been filed as of the date of approval shall be deemed to have been admitted in evidence and shall be deemed to have been transferred to the record of proceedings.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 126 and 5708, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

2. Amendment of section and Note filed 11-17-2008; operative 11-17

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New query

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§10751. Adjudication File.

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a) The Workers' Compensation Appeals Board's adjudication file shall consist of:

(1) all findings, orders, decisions, awards and correspondence issued by the Workers' Compensation Appeals Board, but not including documents that, under the rules of the Court Administrator, shall not be made available for inspection by any person (see current Rule 10271); and

(2) all documents filed by any party, lien claimant, attorney or other agent of record, but not including documents that, under the rules of the Court Administrator, shall not be filed (see current Rule 10222(b)), unless the Workers' Compensation Appeals Board has ordered that the document be filed.

(b) The adjudication file includes the record of proceedings.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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New query

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§10753. Inspection of Files.

Except as provided by sections 10754, 10271, and 10272, or as ordered by a workers' compensation judge or the Appeals Board, the adjudication case files of the Workers' Compensation Appeals Board may be inspected in accordance with the provisions of section 10270.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 126, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

2. Amendment of section and Note filed 11-17-2008; operative 11-17-2008.
Submitted to OAL for printing only (Register 2008, No. 47).

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§10754. Sealed Documents.

Medical reports and other records contained in the adjudication case files of the Workers' Compensation Appeals Board shall be sealed only in accordance with the provisions of section 10272.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 5708, Labor Code.

HISTORY

1. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Amendment of section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10755. Destruction of Records.

Except as otherwise provided by these rules, or as ordered by a workers' compensation judge or the Appeals Board, the adjudication case files of the Workers' Compensation Appeals Board shall be retained, returned, and destroyed in accordance with the provisions of section 10273.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 135, Labor Code.

HISTORY

1. Amendment of section and Note filed 11-17-2008; operative 11-17-2008.
Submitted to OAL for printing only (Register 2008, No. 47).

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§10758. Destruction of Case Files. (Repealed)

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 135, Labor Code.

HISTORY

1. Amendment filed 10-21-96; operative 11-1-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 43).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

3. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10762. Reporters' Notes. [Repealed]

Note: Authority cited: Section 133 and 5307, Labor Code. Reference: Section 14755, Government Code; and Section 5708, Labor Code.

HISTORY

1. Amendment of first paragraph and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10770. Lien Procedure.

(a) Unless the lien claimant is excepted by parts (A) through (C) of section 10228(c)(5), any lien claimant under Labor Code sections 4903 or 4903.1 shall file its lien in writing utilizing an optical character recognition lien form approved by the Appeals Board or electronically as approved by the Administrative Director or the Court Administrator. Lien claimants excepted by parts (A) through (C) of section 10228(c)(5) may file a lien utilizing a non-optical character recognition form provided that it is in the same format and contains the same information as the corresponding OCR form approved by the Appeals Board.

(b) All lien claims filed shall be accompanied by: (1) a full statement or itemized voucher supporting the lien and justifying the right to reimbursement; and (2) a proof of service.

(c) All liens, along with the full statement or itemized voucher supporting the lien, shall be concurrently served as follows:

(1) the injured worker (or, if deceased, the worker's dependent(s)) shall be served, unless: (A) the worker or dependent is represented by an attorney or other agent of record, in which event service may be made solely upon the attorney or agent of record; or (B) the underlying case of the worker or dependent(s) has been resolved. For purposes of this subdivision, the underlying case will be deemed to have been resolved if:

(i) in a stipulated findings and award or in a compromise and release agreement, a defendant has agreed to hold the worker or dependent(s) harmless from the specific lien claim being filed and has agreed to pay, adjust, or litigate that lien;

(ii) a defendant had written notice of the lien in accordance with Labor Code section 4904(a) before the lien was filed and, in a stipulated findings and award or in a compromise and release agreement, that defendant has agreed to hold the worker or dependent harmless from all lien claims and has agreed to pay, adjust, or litigate all liens;

(iii) the application for adjudication of claim filed by the worker or the dependent(s) has been dismissed, and the lien claimant is filing or has filed a new application; or

(iv) the worker or the dependent(s) choose(s) not to proceed with his, her, or their case.

(2) any employer(s) or insurance carrier(s) that are parties to the case shall be served, unless the employer(s) or insurance carrier(s) is/are represented by an attorney or other agent of record, in which event service may be made solely upon the attorney(s) or other agent(s) of record.

Service of a lien on a party shall constitute notice to it of the existence of the lien.

(d) The Workers' Compensation Appeals Board shall not accept for filing a lien that does not bear an adjudication case number previously assigned by the Workers' Compensation Appeals Board for the injury, unless the lien claimant is also filing an initial (case opening) application in accordance with section 10770.5.

(e) The lien claimant shall provide the name, mailing address, and daytime telephone number of a person who will be available at the time of all conferences and trials, and who will have authority to resolve the lien on behalf of the lien claimant.

(f) After a lien has been filed, the lien claimant shall file any amendments to the lien, together with a full statement or itemized voucher supporting the amendment, and it shall serve the amended lien in accordance with subsection (c). When filing an amended lien, the lien claimant shall indicate on the box set forth on the lien form that it is an "amended" lien. For purposes of this subdivision, an "amended" lien includes: (1) a lien that is for or includes additional services or charges for the same injured employee for the same date or dates of injury; (2) a lien that reflects a change in the amount of the lien based on payments made by the defendant; or (3) a lien that has been corrected for clerical or mathematical error. A subsequent lien claim that adds an additional adjudication case number or numbers is an "amended" lien with respect to the adjudication case number(s) originally listed.

(g) Within five business days after a lien has been resolved or withdrawn, the lien claimant shall notify the Workers' Compensation Appeals Board, the party defendant(s), and the worker or dependent(s) (except as provided in subsection (c)).

(h) The lien claimant shall be notified by the Workers' Compensation Appeals Board when any hearing is scheduled, whether or not the hearing directly involves the lien.

(i) Inclusion of the injured employee's Social Security number on a lien form is voluntary, not mandatory. A failure to provide a Social Security number will not have any adverse consequences. Nevertheless, although a lien claimant is not required by law to include the employee's Social Security number, lien claimants are encouraged to do so because this will facilitate the processing and filing of the lien claim. Social Security numbers are used solely for identification and verification purposes in order to administer the workers' compensation system. A Social Security number will not be disclosed, made available, or otherwise used for purposes other than those specified, except with the consent of the applicant, or as permitted or required by statute, regulation, or judicial order.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 4903, 4903.1, 4903.4, 4903.5, 4903.6 and 4904, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

3. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

4. Amendment of section and Note filed 11-17-2008; operative 11-17-2008.
Submitted to OAL for printing only (Register 2008, No. 47).

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§10770.5. Verification to Filing of Lien Claim or Application by Lien Claimant.

(a) Any lien claim or application for adjudication filed under Labor Code section 4903(b) shall have attached to it a verification under penalty of perjury which shall contain a statement specifying in detail the facts establishing that one of the following has occurred:

(1) Sixty days have elapsed since the date of acceptance or rejection of liability for the claim, or the time provided for investigation of liability pursuant to Labor Code section 5402(b) has elapsed, whichever is earlier.

(2) The time provided for payment of medical treatment bills pursuant to Labor Code section 4603.2 has elapsed.

(3) The time provided for payment of medical-legal expenses pursuant to Labor Code section 4622 has elapsed.

(b) In addition, if an application for adjudication is being filed, the verification under penalty of perjury also shall contain:

(1) A statement specifying in detail the facts establishing that venue in the district office being designated is proper pursuant to Labor Code section 5501.5(a)(1) or Labor Code section 5501.5(a)(2); and

(2) A statement specifying in detail the facts establishing that the filing lien claimant has made a diligent search and has determined that no adjudication case number exists for the same injured worker and same date of injury at any district office. A diligent search shall include contacting the injured worker, contacting the employer or carrier, or inquiring at the district office with appropriate venue pursuant to Labor Code section 5501.5(a)(1) or Labor Code section 5501.5(a)(2).

(c) The verification shall be in the following form:

I declare under penalty of perjury under the laws of the State of California that one of the time periods set forth in Rule 10770.5(a) has elapsed and, if an application for adjudication is being filed, that venue is proper as set forth in Rule 10770.5(b) and that I have made a diligent search and have determined that no adjudication case number exists for the same injured worker and the same date of injury. In determining that no adjudication case number exists for the same injured worker and the same date of injury, I have made a diligent search consisting of the

following efforts (specify):

_____

_____

_____

s/s _____ on _____

Failure to attach the verification or an incorrect verification may be a basis for sanctions.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 4903 and 4903.6, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10770.6. Verification to Filing of Declaration of Readiness By or on Behalf of Lien Claimant.

No Declaration of Readiness to Proceed shall be filed for a lien under Labor Code section 4903(b) without an attached verification certifying under penalty of perjury either (1) that the underlying case has been resolved or (2) that at least six months have elapsed from the date of injury and the injured worker has chosen not to proceed with his or her case. The declarant shall make a diligent search to determine that the injured worker has chosen not to proceed with his or her case and the verification shall specify the efforts made in conducting the diligent search. A diligent search shall include contacting the injured worker, contacting the employer or carrier, or inquiring at the district office with appropriate venue pursuant to Labor Code section 5501.5(a)(1) or Labor Code section 5501.5(a)(2).

The verification shall be in the following form:

I declare under penalty of perjury under the laws of the State of California: (Check at least one box)

[ ] that the underlying case has been resolved.

[ ] that at least six months have elapsed from the date of injury and the injured worker has chosen not to proceed with his or her case. In determining that the injured worker has chosen not to proceed with his or her case, I have made a diligent search consisting of the following efforts (specify):

_____

_____

_____

_____

s/s _____ on _____

Failure to attach the verification or an incorrect verification may be a basis for sanctions.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 4903 and 4903.6, Labor Code.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10771.Medical-Legal Expense. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4903 and 4903.1, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

3. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10772. Unemployment Compensation Disability Liens.

When an unemployment compensation disability lien is filed by the Employment Development Department, there shall be a rebuttable presumption that the amounts stated therein have been paid to the injured worker by the Employment Development Department.
In any case involving a lien claim for unemployment compensation disability benefits or unemployment compensation benefits and extended duration benefits where it appears that further benefits may have been paid subsequent to the filing of the claim of lien, the workers' compensation judge shall notify the lien claimant when the case is ready for decision or for order approving compromise and release and the lien claimant shall have five (5) days thereafter in which to file and serve an amended lien reflecting all payments made to and including the date of filing of the amended lien.
In cases where a compromise and release is filed and continuing unemployment compensation disability benefits or unemployment compensation benefits and extended duration benefits are being paid, the workers' compensation judge will ascertain the full amount of the lien claim as of the time of the approval of the compromise and release so that the allocation made under the authority of Labor Code Section 4904 may be changed to reflect unemployment compensation disability or unemployment compensation and extended duration payments to the date of decision.

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4903 and 4904, Labor Code.

HISTORY

1. Amendment of last paragraph filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10773. Law Firm Employees.

(a) Law firm employees not holding current active membership in the State Bar may appear on behalf of the law firm if:

(1) the client has been fully informed of the involvement of the law firm employee and that the person is not a current active member of the State Bar of California;

(2) in all proceedings where the law firm employee appears and in all documents the person has prepared, the person appearing or preparing the documents is identified and it is fully disclosed that the person is not licensed to practice law in the State of California; and

(3) the attorney directly responsible for supervising the law firm employee appearing in any proceedings is identified.

(b) A workers' compensation judge shall not approve any compromise and release agreement or stipulations with request for award signed by a law firm employee who is not currently an active member of the State Bar of California without the specific written authorization of the attorney directly responsible for supervising the law firm employee.

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 4907, Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51). For prior history, see Register 96, No. 43.

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New query

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§10774. Substitution or Dismissal of Attorneys.

Substitution or dismissal of attorneys must be made in the manner provided by Code of Civil Procedure Sections 284, 285 and 286. Dismissal of agents may be made by serving and filing a statement of dismissal.

NOTE: Authority cited: Sections 133, 5307, Labor Code. Reference: Sections 4903, 4906, Labor Code.

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§10775. Reasonable Attorney's Fee.

In establishing a reasonable attorney's fee, the workers' compensation judge or arbitrator shall consider the

(a) responsibility assumed by the attorney,

(b) care exercised in representing the applicant,

(c) time involved,

(d) results obtained.

Reference will be made to guidelines contained in the Policy and Procedural Manual and workers' compensation judges and arbitrators shall at all times comply with Labor Code section 5313 by setting forth the reasons or grounds for applying the guidelines in any fee determination.

Through its power to grant reconsideration on its own motion, the Appeals Board shall exercise authority to ascertain the extent to which these guidelines are followed.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4903 and 4906, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment of first and penultimate paragraphs filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10776. Approval of Attorney's Fee.

(a) No request for payment or demand for payment of a fee shall be made by any attorney for, or agent of, a worker or dependent of a worker until the fee has been approved or set by the Workers' Compensation Appeals Board.

(b) No attorney or agent shall accept any money from a worker or dependent of a worker for the purpose of representing the worker or dependent of a worker before the Workers' Compensation Appeals Board or in any appellate procedure related thereto until the fee has been approved or set by the Workers' Compensation Appeals Board or an appellate court.

(c) Any agreement between any attorney or agent and a worker or dependent of a worker for payment of a fee shall be submitted to the Workers' Compensation Appeals Board for approval within ten (10) days after the agreement is made.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4903 and 4906, Labor Code.

HISTORY

1. Amendment of subsections (a)-(b) filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10778. Request for Increase of Attorney's Fee.

All requests for an increase in attorney's fee shall be accompanied by proof of service on the applicant of written notice of the attorney's adverse interest and of the applicant's right to seek independent counsel. Failure to so notify the applicant may constitute grounds for dismissal of the request for increase in fee.

NOTE: Authority cited: Sections 133, 5307, Labor Code. Reference: Sections 4903, 4906, Labor Code.

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§10779. Disbarred and Suspended Attorneys.

An attorney who has been disbarred or suspended by the Supreme Court for reasons other than nonpayment of State Bar fees, or who has been placed on involuntary inactive enrollment status by the State Bar, or who has resigned while disciplinary action is pending shall be deemed unfit to appear as a representative of any party before the Workers' Compensation Appeals Board during the time that the attorney is precluded from practicing law in this state.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 4907, Labor Code; and Section 6126, Business and Professions Code.

HISTORY

1. Amendment of first paragraph filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Amendment of section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10780. Dismissal Orders.

Except as provided in Rule 10562 and 10582 and unless good cause to the contrary appears, orders of dismissal of claim forms for injuries on or after January 1, 1990 and before January 1, 1994, and orders of dismissal of applications for adjudication for injuries before January 1, 1990 and on or after January 1, 1994, shall issue forthwith when requested by the employee. All other orders of dismissal of claim forms for injuries occurring on or after January 1, 1990 and before January 1, 1994, or orders of dismissal of applications for adjudication for injuries occurring before January 1, 1990 and on or after January 1, 1994, shall issue only after service of a notice of intention allowing at least fifteen (15) days for the adverse parties to show good cause to the contrary, and not by an order with a clause rendering the order null and void if an objection showing good cause is filed.

NOTE

Authority cited: Sections 133 and 5307, Labor Code.

HISTORY

1. Repealer and new section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10782. Vexatious Litigants.

(a) For purposes of this rule, "vexatious litigant" means:

(1) A party or lien claimant who, while acting in propria persona (i.e., while representing himself or herself) in proceedings before the Workers' Compensation Appeals Board, repeatedly relitigates, or attempts to relitigate, an issue of law or fact that has been finally determined against that party or lien claimant by the Workers' Compensation Appeals Board or by an appellate court;

(2) A party or lien claimant who, while acting in propria persona in proceedings before the Workers' Compensation Appeals Board, repeatedly files unmeritorious motions, pleadings, or other papers, repeatedly conducts or attempts to conduct unnecessary discovery, or repeatedly engages in other tactics that are in bad faith, are frivolous, or are solely intended to cause harassment or unnecessary delay; or

(3) A party or lien claimant who has previously been declared to be a vexatious litigant by any state or federal court of record in any action or proceeding based upon the same or substantially similar facts, transaction(s), or occurrence(s) that are the subject, in whole or in substantial part, of the party or lien claimant's workers' compensation case.

For purposes of this rule, the phrase "finally determined" shall mean: (i) that all appeals have been exhausted or the time for seeking appellate review has expired; and (ii) the time for reopening under Labor Code sections 5410 or 5803 and 5804 has passed or, although the time for reopening under those sections has not passed, there is no good faith and non-frivolous basis for reopening.

(b) Upon the petition of a party or lien claimant, or upon the motion of any workers' compensation judge or the Appeals Board, a presiding workers' compensation judge of any district office having venue or the Appeals Board may declare a party or lien claimant as a vexatious litigant.

(c) No party or lien claimant shall be declared a vexatious litigant without being given notice and an opportunity to be heard. If a hearing is requested, the presiding workers' compensation judge or the Appeals Board, in his, her or its discretion, either may take and consider both oral and documentary evidence or may take and consider solely documentary evidence, including affidavits or other written declarations of fact made under penalty of perjury.

(d) If a party or lien claimant is declared to be a vexatious litigant, a presiding workers' compensation judge or the

Appeals Board may enter a "prefiling order," i.e., an order which prohibits the vexatious litigant from filing, in propria persona, any Application for Adjudication of Claim, Declaration of Readiness, petition, or other request for action by the Workers' Compensation Appeals Board without first obtaining leave of the presiding workers' compensation judge of the district office where the request for action is proposed to be filed or, if the matter is pending before the Appeals Board on a petition for reconsideration, removal, or disqualification, without first obtaining leave from the Appeals Board. For purposes of this rule, a "petition" shall include, but not be limited to, a petition to reopen under Labor Code sections 5410, 5803, and 5804, a petition to enforce a medical treatment award, a penalty petition, or any other petition seeking to enforce or expand the vexatious litigant's previously determined rights.

(e) If a vexatious litigant proposes to file, in propria persona, any Application for Adjudication of Claim, Declaration of Readiness, petition, or other request for action by the Workers' Compensation Appeals Board, the request for action shall be conditionally filed. Thereafter, the presiding workers' compensation judge, or the Appeals Board if the petition is for reconsideration, removal, or disqualification, shall deem the request for action to have been properly filed only if it appears that the request for action has not been filed in violation of subdivision (a). In determining whether the vexatious litigant's request for action has not been filed in violation of subdivision (a), the presiding workers' compensation judge, or the Appeals Board, shall consider the contents of the request for action and the Workers' Compensation Appeals Board's existing record of proceedings, as well as any other documentation that, in its discretion, the presiding workers' compensation judge or the Appeals Board asks to be submitted. Among the factors that the presiding workers' compensation judge or the Appeals Board may consider is whether there has been a significant change in circumstances (such as new or newly discovered evidence or a change in the law) that might materially affect an issue of fact or law that was previously finally determined against the vexatious litigant.

(f) If any in propria persona Application for Adjudication of Claim, Declaration of Readiness, petition, or other request for action by the Workers' Compensation Appeals Board from a vexatious litigant subject to a prefiling order is inadvertently accepted for filing (other than conditional filing in accordance with subdivision (e), above), then any other party or lien claimant may file (and shall concurrently serve on the vexatious litigant and any other affected parties or lien claimants) a notice stating that the request for action is being submitted by a vexatious litigant subject to a prefiling order as set forth in subdivision (d). The filing of the notice shall automatically stay the request for action until it is determined, in accordance with subdivision (e), whether the request for action should be deemed to have been properly filed.

(g) A copy of any prefiling order issued by a presiding workers' compensation judge or by the Appeals Board shall be submitted to the Secretary of the Appeals Board, who shall maintain a record of vexatious litigants subject to those prefiling orders and who shall annually disseminate a list of those persons to all presiding workers' compensation judges.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Article XIV, section 4, California Constitution; and Sections 391, 391.2, and 391.7, Code of Civil Procedure.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10785. Electronically Filed Decisions, Findings, Awards, and Orders.

The Appeals Board or a workers' compensation judge may electronically file any decision, findings, award, order or other document within EAMS, either by preparing the document in paper form and then scanning it into EAMS or by preparing the document directly within EAMS. Any such electronically filed document shall have the same legal effect as a document filed in paper form.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 126, 5313 and 5908.5.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10820. When Certified Copies Will Issue.

Certified copies of findings and awards or other final orders for the purpose of having judgment entered and execution issued by the clerk of a superior court shall be issued only upon written request of a person entitled to benefits thereunder or by the attorney or authorized representative, and upon payment of the fees prescribed by the Rules of the Administrative Director.

Certified copies of such orders and awards against authorized insurance carriers, authorized self-insured employers, the State of California and all political subdivisions thereof shall be issued only upon receipt of a written request showing good cause therefor.

Every request for a certified copy of any final order must state whether proceedings are pending on reconsideration or judicial review, whether a petition for reconsideration or a writ of review has been filed, and whether the decision, a certified copy of which is requested has become final.

Nothing in these rules, however, shall limit the power of the Workers' Compensation Appeals Board to issue a certified copy at any time upon its own motion without charge.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5806, 5807 and 5808, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10825. Withholding Certified Copies.

As an alternative to the issuance of an order staying execution, the Workers' Compensation Appeals Board may direct by order that no certified copy be issued. Such an order shall have the same effect as an order staying execution issued under similar circumstances.

(a) Before staying execution or issuing order withholding issuance of a certified copy of an order, decision or award, the Workers' Compensation Appeals Board in its discretion may require the filing of a bond from an approved surety equivalent to twice the probable amount of liability in the case.

(b) The bond shall be filed in the record of the case.

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 130, 134, 5105, 5806, 5807, 5808, 5809, 6000, 6001 and 6002, Labor Code.

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§10828. Necessity for Bond.

Where a party intending to file for writ of review requests a stay of execution or withholding issuance of a certified copy of the order, decision or award that is the subject of the party's complaint, the request will ordinarily be granted, conditioned upon the filing of a bond from an approved surety equivalent to twice the probable amount of liability in the case.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5808, 5956, 6000, 6001 and 6002, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10832. Proceedings to Enforce Awards. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 134 and 5300, Labor Code.

HISTORY

1. Repealer filed 10-21-96; operative 11-1-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 43).

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§10840. Filing Petitions for Reconsideration, Removal, and Disqualification and Answers.

(a) Except as provided in sections 10865 and 10953, petitions for reconsideration, removal, or disqualification and answers thereto may be filed with any district office of the Workers' Compensation Appeals Board or with the office of the Appeals Board in San Francisco. Duplicate copies of petitions filed with a district office shall not also be filed with any other district office or with the Appeals Board in San Francisco.
(b) Except as provided in sections 10865 and 10953, the following persons and entities may file petitions for reconsideration, removal, or disqualification (and answers thereto) electronically within EAMS:

(a) a party, lien claimant, attorney, or other representative who has been assigned an individual EAMS login and password by the Division of Workers' Compensation as part of an electronic filing trial group; and

(b) a law firm, an insurance company, a self-insured employer, a third party administrator, or lien claimant who has been assigned an organizational EAMS login and password by the Division of Workers' Compensation as part of an electronic filing trial group.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5900, 5902 and 5905, Labor Code.

HISTORY

1. Repealer and new section filed 12-16-92; operative 2-1-93 and exempt from OAL review pursuant to Government Code section 11351 (Register 92, No. 51).

2. Amendment of section heading and text filed 12-23-93; operative 1-1-94.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 93, No. 52).

3. Amendment of article heading, section heading, section and Note filed 11-17- 2008; operative 11-17 2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10842. Contents of Petitions for Reconsideration, Removal, and Disqualification and Answers.

(a) Every petition for reconsideration, removal, or disqualification shall fairly state all of the material evidence relative to the point or points at issue. Each contention contained in a petition for reconsideration, removal, or disqualification shall be separately stated and clearly set forth. A failure to fairly state all of the material evidence may be a basis for denying the petition.
(b) Each petition for reconsideration, removal, or disqualification, and each answer thereto, shall support its evidentiary statements by specific references to the record.

(1) References to any stipulations, issues, or testimony contained in any Minutes of Hearing, Summary of Evidence, or hearing transcript shall specify: (A) the date and time of the hearing; and (B) if available, the page(s) and line number(s) of the Minutes, Summary, or transcript to which the evidentiary statement relates (e.g., "Summary of Evidence, 5/1/08 trial, 1:30pm session, at 6:11-6:15").

(2) References to any documentary evidence shall specify: (A) the exhibit number or letter of the document; (B) the date and time of the hearing at which the document was admitted or offered into evidence; (C) where applicable, the author(s) of the document; (D) where applicable, the date(s) of the document; and (E) the relevant page number(s) and, if available, at least one other relevant identifier (e.g., line number(s), paragraph number(s), section heading(s)) that helps pinpoint the reference within the document (e.g., "the 6/16/08 report of John A. Jones, M.D., at p. 7, Apportionment Discussion, 3rd full ¶ [Defendant's Exh. B, admitted at 8/1/08 trial, 1:30pm session]").

(3) References to any deposition transcript shall specify: (A) the exhibit number or letter of the document; (B) the date and time of the hearing at which the deposition transcript was admitted or offered into evidence; (C) the name of the person deposed; (D) the date and time of the deposition; and (E) the relevant page number(s) and line(s) (e.g., "the 6/20/08 depo of William A. Smith, M.D., at 21:20-22:5 [Applicant's Exh. 3, admitted at 12/1/08 trial, 8:30am session]").

(c) Copies of documents that have already been received in evidence or that have already been made part of the adjudication file shall not be attached as exhibits to petitions for reconsideration, removal, or disqualification or answers thereto. Except as provided by section 10856, documents attached in violation of this rule may be detached from the petition or answer and discarded.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 126, 5310, 5311, 5900,

5902 and 5904, Labor Code.

HISTORY

1. New section filed 5-25-82; designated effective 7-1-82 (Register 82, No. 22).

2. Amendment of section heading and text filed 12-23-93; operative 1-1-94.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 93, No. 52).

3. Amendment of last paragraph filed 12-19-2002; operative 1-1-2003. Submitted
to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

4. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-
2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10843. Petitions for Removal and Answers.

(a) At any time within twenty (20) days after the service of the order or decision, or of the occurrence of the action in issue, any party may petition for removal based upon one or more of the following grounds:

(1) The order, decision or action will result in significant prejudice.

(2) The order, decision or action will result in irreparable harm.

The petitioner must also demonstrate that reconsideration will not be an adequate remedy after the issuance of a final order, decision or award. Failure to file the petition to remove timely shall constitute valid ground for dismissing the petition for removal.

(b) The petition for removal and any answer thereto shall be verified upon oath in the manner required for verified pleadings in courts of record.

(c) A copy of the petition for removal shall be served forthwith upon all parties by the petitioner. Any adverse party may file an answer within ten (10) days after service. No supplemental petitions, pleadings or responses shall be considered unless requested or approved by the Appeals Board.

(d) The workers' compensation judge may, within fifteen (15) days of the filing of the petition for removal, rescind the order or decision in issue, or take action to resolve the issue raised in the petition. If the judge so acts, or if the petitioner withdraws the petition at any time, the petition for removal will be deemed automatically dismissed, requiring no further action by the Appeals Board. The issuance of a new order or decision, or the occurrence of a new action, will recommence the time period for filing a petition for removal as described above.

(e) The filing of a petition for removal does not terminate the judge's authority to proceed in a case or require the judge to continue or cancel a previously scheduled hearing absent direction from the Appeals Board. After a petition for removal has been filed, the workers' compensation judge shall consult with the presiding workers' compensation judge prior to proceeding in the case or continuing or canceling a scheduled hearing.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 5310, Labor Code.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment filed 12-12-2000; operative 1-1-2001. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2000, No. 50).
3. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

4. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10844. Petitions for Disqualification and Answers.

In addition to the requirements of section 10452, the petition for disqualification and any answer thereto shall be verified upon oath in the manner required for verified pleadings in courts of record.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 5311, Labor Code; and Section 641, Code of Civil Procedure.

HISTORY

1. New section filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10846. Skeletal Petitions.

A petition for reconsideration, removal, or disqualification may be denied or dismissed if it is unsupported by specific references to the record and to the principles of law involved.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5310, 5311, 5902, 5903 and 5904, Labor Code.

HISTORY

1. Amendment of section and Note filed 11-17-2008; operative 11-17-2008.
Submitted to OAL for printing only (Register 2008, No. 47).

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§10848. Supplemental Petitions.

When a petition for reconsideration, removal or disqualification has been timely filed, supplemental petitions or pleadings or responses other than the answer shall be considered only when specifically requested or approved by the Appeals Board. Supplemental petitions or pleadings or responses other than the answer, except as provided by this rule, shall neither be accepted nor deemed filed for any purpose and shall not be acknowledged or returned to the filing party.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5310, 5311 and 5900, Labor Code.

HISTORY

1. Repealer and new section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment of section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10850. Proof of Service.

Service of copies of any petition for reconsideration, removal, or disqualification or any answer thereto shall be made, in accordance with Rule 10505, on all parties to the case and on any lien claimant, the validity of whose lien is specifically questioned by the petition, and to any case that has been consolidated therewith pursuant to Section 10590. Failure to file proof of service shall constitute valid ground for dismissing the petition.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5310, 5311, 5902 and 5903, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

2. Amendment of section and Note filed 11-17-2008; operative 11-17-2008.
Submitted to OAL for printing only (Register 2008, No. 47).

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§10852. Insufficiency of Evidence.

Where reconsideration is sought on the ground that findings are not justified by the evidence, the petition shall set out specifically and in detail how the evidence fails to justify the findings.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5902 and 5903, Labor Code.

HISTORY

1. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10856. Allegations of Newly Discovered Evidence and Fraud.

Where reconsideration is sought on the ground of newly discovered evidence that could not with reasonable diligence have been produced before submission of the case or on the ground that the decision had been procured by fraud, the petition must contain an offer of proof, specific and detailed, providing:

(a) the names of witnesses to be produced;

(b) a summary of the testimony to be elicited from the witnesses;

(c) a description of any documentary evidence to be offered;

(d) the effect that the evidence will have on the record and on the prior decision; and

(e) as to newly discovered evidence, a full and accurate statement of the reasons why the testimony or exhibits could not reasonably have been discovered or produced before submission of the case.

A petition for reconsideration sought upon these grounds may be denied if it fails to meet the requirements of this rule, or if it is based upon cumulative evidence.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5902 and 5903, Labor Code.

HISTORY

1. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10858. Correction of Errors.

Before a petition for reconsideration is filed, a workers' compensation judge may correct the decision for clerical, mathematical or procedural error or amend the decision for good cause under the authority and subject to the limitations set out in Sections 5803 and 5804 of the Labor Code.

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5309, Labor Code.

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§10859. Orders After Filing of Petition for Reconsideration.

After a petition for reconsideration has been timely filed, a workers' compensation judge may, within the period of fifteen (15) days following the date of filing of that petition for reconsideration, amend or modify the order, decision or award or rescind the order, decision or award and conduct further proceedings. Further proceedings shall be initiated within 30 days from the order of recession. The time for filing a petition for reconsideration pursuant to Labor Code section 5903 will run from the filing date of the new, amended or modified decision. After this period of fifteen (15) days has elapsed, a workers' compensation judge shall not make any order in the case nor correct any error until the Appeals Board has denied or dismissed the petition for reconsideration or issued a decision after reconsideration.

NOTE

Authority cited: Section 5307, Labor Code. Reference: Sections 5906, 5907 and 5908.5, Labor Code.

HISTORY

1. Repealer and new section filed 12-16-92; operative 2-1-93 and exempt from OAL review pursuant to Government Code section 11351 (Register 92, No. 51).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10860. Report of Workers' Compensation Judge.

Petitions for reconsideration, petitions for removal and petitions for disqualification shall be referred to the workers' compensation judge from whose decisions or actions relief is sought. The workers' compensation judge shall prepare a report that shall contain:

(a) a statement of the contentions raised by the petition;

(b) a discussion of the support in the record for the findings of fact and the conclusions of law that serve as a basis for the decision or order as to each contention raised by the petition, or, in the case of a petition for disqualification, a specific response to the allegations and, if appropriate, a discussion of any failure by the petitioner to comply with the procedures set forth in Rule 10452, and

(c) the action recommended on the petition.

The workers' compensation judge shall submit the report to the Appeals Board within 15 days after the petition is filed unless the Appeals Board grants an extension of time. The workers' compensation judge shall serve a copy of the report on the parties and any lien claimant, the validity of whose lien is specifically questioned by the petition, at the time the report is submitted to the Appeals Board.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5900 and 5906, Labor Code.

HISTORY

1. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

3. Amendment of section and Note filed 11-17-2008; operative 11-17-2008.
Submitted to OAL for printing only (Register 2008, No. 47).

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§10862. Hearing After Reconsideration Granted.

Where reconsideration has been granted and the case referred to a workers' compensation judge for proceedings on reconsideration, the workers' compensation judge shall, upon the conclusion thereof, prepare and serve upon the parties a summary of evidence received in the proceedings after reconsideration granted.

Unless otherwise instructed by the panel before which a case is pending, the workers' compensation judge to whom the case has been assigned for further proceedings may rule on requests for postponement, continuance of further hearing, join additional parties, dismiss unnecessary parties where such dismissal is not opposed by any other party to the case, make all interlocutory or procedural orders that are agreed to by all parties, issue subpoenas, rule on motions for discovery, rule on all evidentiary motions and objections, and make all other rulings necessary to expedite and facilitate the trial and disposition of the case. The workers' compensation judge shall not order a medical examination, obtain a recommended disability evaluation, make an order taking the case off calendar, nor make an order approving or disapproving compromise and release.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5309 and 5313, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10864. Authority of Workers' Compensation Judge After Decision After Reconsideration.

After a decision after reconsideration has become final, subsequent orders and decisions in a case may be made by any workers' compensation judge to whom the case is assigned pursuant to Section 10348, including orders approving or disapproving compromise and release, orders allowing or disallowing liens, orders for enforcement of the decision of the Appeals Board, orders granting or denying petitions to reopen, orders rescinding, altering or amending the decision of the Appeals Board for good cause under Labor Code Section 5803, orders for increased compensation under Labor Code Section 5814, orders terminating liability, orders for commutation and orders resolving issues that the Board in its decision has left for determination by a workers' compensation judge.

A workers' compensation judge may not make an order correcting a decision after reconsideration for clerical, mathematical, or procedural error. Requests for such correction shall be acted on by the panel that made the decision or if the composition of the Board has changed, by the successor panel.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5900, 5910 and 5911, Labor Code.

HISTORY

1. Amendment filed 5-25-82; designated effective 7-1-82 (Register 82, No. 22).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10865. Reconsideration of Arbitration Decisions Made Pursuant To-Labor Code Sections 3201.5 and 3201.7.

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a) A petition for reconsideration from an arbitration decision made pursuant to Labor Code Section 3201.5(a)(1) or Section 3201.7(a)(1) (known as "carve-out" cases) shall be filed directly with the office of the Appeals Board in San Francisco within twenty (20) days of the service of the final order, decision, or award made and filed by the arbitrator or board of arbitrators. A copy of the petition for reconsideration shall be served on the arbitrator or arbitration board.

(b) Notwithstanding any other provision of these rules, a petition for reconsideration in a carve-out case shall be filed directly with the office of the Appeals Board in San Francisco, and not with any district office, including the San Francisco district office. The street address and the post office box address of the Appeals Board may be found at the website of the Department of Industrial Relations, Workers' Compensation Appeals Board (currently, at http://www.dir.ca.gov/wcab/WCAB_PetitionforReconsideration.htm) or by telephoning the Appeals Board in San Francisco (currently, (415) 703-4550). Any petition for reconsideration in a carve-out case that is received by any district office shall neither be accepted for filing nor deemed filed for any purpose. If a carve-out petition for reconsideration is submitted to a district office in violation of this rule, the petition shall be returned to the petitioner with a letter referencing this rule, noting that the petition was improperly submitted to a district office and has been rejected, and indicating that the petition should be filed directly with the Appeals Board in San Francisco consistent with this rule.

(c) The petition for reconsideration in a carve-out case, which shall be submitted with a document cover sheet, shall also comply with each of the following requirements:

(1) it shall be captioned so as to identify it as a "Petition for Reconsideration from Arbitrator's Decision Under Labor Code section 3201.5 or 3201.7" and it shall caption: (A) the injured employee's first and last names; (B) the name(s) of the defendant(s); (C) the alternative dispute resolution (ADR) case number (i.e., the carve-out arbitration case number); and (D) the Workers' Compensation Appeals Board adjudication case number, if previously assigned;

(2) it shall set forth the date on which the arbitrator or board of arbitrators served the arbitration decision. Proof of service of the arbitration decision on the parties shall be either by a verified statement of the arbitrator or the board of arbitrators indicating the date of service and listing the names and addresses of the persons served or by written acknowledgment of receipt by the parties at the time of the arbitration proceedings;

(3) it shall append, under a document separator sheet a copy of that portion of the collective bargaining agreement relating to the workers' compensation arbitration and reconsideration processes;

(4) it shall append, under a document separator sheet, a completed application for adjudication of claim (but without any venue designation), which is required solely for the purpose of obtaining the information set forth therein (e.g., the injured employee's date(s) of injury and date of birth; the names and mailing addresses of the parties); therefore, it shall not be deemed an application for purposes of Labor Code section 4064(c); and

(5) it shall contain a proof of service of the petition, including service on the arbitrator or board of arbitrators.

(d) After the filing of the carve-out petition for reconsideration, an adjudication file will be created and an adjudication case number will be assigned, if there is no existing adjudication case number. Any new adjudication case number will be served by the Appeals Board on the parties and attorneys, and on the arbitrator or board of arbitrators, at the addresses listed in the proof of service to the petition.

(e) Following the Appeals Board's service of the adjudication case number (or, if there is an existing case, following the filing of the carve-out petition for reconsideration), and until the Appeals Board issues a decision disposing of all issues raised in the petition, all further documents shall be filed directly with the office of the Appeals Board in San Francisco, and not with any district office.

(f) Within 15 days after receiving the petition for reconsideration, the arbitrator or board of arbitrators shall submit to the Appeals Board in San Francisco a photocopy of the complete record of proceedings, including: (1) the transcript of proceedings, if any; (2) a summary of testimony if the proceedings were not transcribed; (3) the documentary evidence submitted by each of the parties; (4) an opinion that sets forth the rationale for the decision; and (5) a report on the petition for reconsideration, consistent with the provisions of section 10860. The original arbitration record shall not be filed.

(g) The Appeals Board may scan the petition for reconsideration, any answer, and the photocopied record of the arbitration proceedings into the adjudication file within EAMS. Upon scanning, the paper documents shall be destroyed.

(h) The petition for reconsideration, any answer, and the arbitration record shall be deemed part of the Workers' Compensation Appeals Board's record of proceedings under section 10750.

(i) After an arbitration decision has been made, the arbitrator or board of arbitrators shall maintain possession of the original record of the arbitration proceedings until the time for filing a petition for reconsideration has passed. Thereafter one of the parties may be designated custodian of the arbitration record as provided for in the collective bargaining agreement.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 3201.5 and 3201.7, Labor Code.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment of section heading, section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Codesection 11351 (Register 2002, No. 51).

3. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-

2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10866. Reconsideration of Arbitrator's Decisions or Awards Made Pursuant to the Mandatory or Voluntary Arbitration Provisions of Labor Code Sections 5270 through 5275.

(a) Any final order, decision or award filed by an arbitrator under the mandatory or voluntary arbitration provisions of Labor Code Sections 5270 through 5275 shall be subject to the reconsideration process as set forth in Labor Code Sections 5900 through 5911 and Rules 10842 through 10850. The parties, respectively, shall serve the arbitrator with the petition for reconsideration and the answer.

(b) A petition for reconsideration from any final order, decision or award filed by an arbitrator under the mandatory or voluntary arbitration provisions of Labor Code sections 5270 through 5275, and any answer to such a petition, may be filed with any district office or with the office of the Appeals Board in San Francisco. Duplicate copies of petitions filed with a district office shall not also be filed with any other district office or with the Appeals Board in San Francisco.

(c) When a petition for reconsideration is filed from any final order, decision or award made by an arbitrator under Labor Code Sections 5270 through 5275, the arbitrator shall prepare and serve a report on reconsideration as provided in Rule 10860. Upon completion of the report on reconsideration, the arbitrator shall concurrently forward the arbitrator's original report and a photocopy of the complete arbitration file directly to the presiding workers' compensation judge of the district office having venue over the matter. Upon receipt of the arbitrator's original report and the photocopy of the arbitration file, the district office shall scan the report and the photocopied file into the EAMS adjudication file and, after scanning, shall destroy these documents. Thereafter, the adjudication file shall be electronically transferred to the Appeals Board for action on the petition for reconsideration or, to the extent that the adjudication file is in paper form, the file shall be delivered to the Appeals Board.

(d) The petition for reconsideration, any answer, and the arbitration record shall be deemed part of the Workers' Compensation Appeals Board's record of proceedings under section 10750.

(e) The costs of photocopying the arbitrator's file shall be reimbursed to the arbitrator in accordance with the provisions of Labor Code section 5273, within 30 days after the liable party or parties receives the arbitrator's billing for those costs.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 5273, 5275, 5277(c) and 5900-5911, Labor Code.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

3. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-
2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10867. Report of Arbitrator. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5275, 5277(c) and 5900-5911, Labor Code.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

3. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10868. Reconsideration of Settlement Conference Referees' Decisions or Awards.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 111, 5502 and 5900, Labor Code.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10869. Report of Settlement Conference Referee.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 111, 5502 and 5307, Labor Code.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10870. Approval of Compromise and Release.

Agreements that provide for the payment of less than the full amount of compensation due or to become due and undertake to release the employer from all future liability will be approved only where it appears that a reasonable doubt exists as to the rights of the parties or that approval is in the best interest of the parties. No agreement shall relieve an employer of liability for vocational rehabilitation benefits unless the Workers' Compensation Appeals Board makes a finding that there is a good faith issue which, if resolved against the injured employee, would defeat the employee's right to all workers' compensation benefits.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4646, 5001, 5002 and 5100.6, Labor Code.

HISTORY

1. Amendment of article 18 heading and amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10874. Form.

Every compromise and release agreement shall comply with the provisions of Labor Code Sections 5003-5004 and conform to a form provided by the Appeals Board.

NOTE: Authority cited: Sections 133, 5307, Labor Code. Reference: Sections 5001, 5002, 5003, 5004, Labor Code.

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§10875. Procedures--Labor Code Section 3761.

Where the insurer has attached a declaration to the compromise and release agreement or stipulations with request for award that it has complied with the provisions of Labor Code Sections 3761, subdivision (a), and 3761, subdivision (b), the Workers' Compensation Appeals Board may approve the compromise and release or stipulations with request for award without hearing or further proceedings.

Where a workers' compensation judge or the Appeals Board has approved a compromise and release or stipulations with request for award and the insurer has failed to show proof of service pursuant to Labor Code Section 3761, subdivision (b), the workers' compensation judge or the Appeals Board, after giving notice and an opportunity to be heard to the insurer, shall award expenses as provided in Labor Code Section 5813 upon request by the employer.

Any request for relief under Labor Code Section 3761, subdivision (b), or Labor Code Section 3761, subdivision (d), shall be made by the filing of a petition pursuant to Rule 10450, together with a Declaration of Readiness to Proceed.

This rule shall apply to injuries on or after January 1, 1994.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 3761, Labor Code.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment of penultimate paragraph filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10878. Settlement Document as an Application.

The filing of a compromise and release agreement or stipulations with request for award shall constitute the filing of an application which may, in the Workers' Compensation Appeals Board's discretion, be set for hearing, reserving to the parties the right to put in issue facts that might otherwise have been admitted in the compromise and release agreement or stipulations with request for award. If a hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document. The Workers' Compensation Appeals Board may thereafter either approve the settlement agreement or disapprove it and issue findings and award after hearing has been held and the matter submitted for decision.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5001, 5002, 5500 and 5702, Labor Code.

HISTORY

1. Amendment of section heading, section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10882. Action on Settlement Agreement.

The Workers' Compensation Appeals Board shall inquire into the adequacy of all compromise and release agreements and stipulations with request for award, and may set the matter for hearing to take evidence when necessary to determine whether the agreement should be approved or disapproved, or issue findings and awards.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5001, 5002 and 5702, Labor Code.

HISTORY

1. Amendment of section heading, section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10886. Service on Lien Claimants.

Where a lien claim is on file with the Workers' Compensation Appeals Board or where a party has been served with a lien, and a compromise and release agreement or stipulations with request for award or order is filed, a copy of the compromise and release agreement or stipulations shall be served on the lien claimant.

No lien claim shall be disallowed or reduced unless the lien claimant has been given notice and an opportunity to be heard.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4903, 4903.1, 4903.4, 4904, 4904.1, 4905 and 4906, Labor Code.

HISTORY

1. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10888 . Resolution of Liens.

Before issuance of an order approving compromise and release that resolves a case or an award that resolves a case based upon the stipulations of the parties, if there remain any liens that have not been resolved or withdrawn, the parties shall make a good-faith attempt to contact the lien claimants and resolve their liens. A good-faith attempt requires at least one contact of each lien claimant by telephone or letter.

After issuing an order approving compromise and release that resolves a case or an award that resolves a case based upon the stipulations of the parties, if there remain any liens that have not been resolved or withdrawn, the workers' compensation judge shall

(1) set the case for a lien conference, or

(2) issue a ten (10) day notice of intention to order payment of any such lien in full or in part, or

(3) issue a ten (10) day notice of intention to disallow any such lien. Upon a showing of good cause, the workers' compensation judge may once continue a lien conference to another lien conference. If a lien cannot be resolved at a lien conference, the workers' compensation judge shall set the case for trial.

An agreement to “pay, adjust or litigate” a lien, or its equivalent, or an award leaving a lien to be adjusted, is not a resolution of the lien.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4903, 4903.1, 4904, 5001, 5002 and 5702, Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10890. Walk-Through Documents. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4053, 4054, 5001, 5002, 5702 and 5710, Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10940. Application.

All claims against the Subsequent Injuries Fund shall be by an application in writing setting forth the date and nature of the industrial injury, together with all factors of disability alleged to have pre-existed said injury. Allegations of additional factors must be by amended application.

All applications against the Subsequent Injuries Fund shall be filed with the Appeals Board and a copy shall be served by mail on the Division of Workers' Compensation, Subsequent Injuries Fund, in accordance with Sections 10505 and 10507. Where joinder of the Subsequent Injuries Fund has been ordered by the workers' compensation judge or the Appeals Board, the applicant shall forthwith file and serve an application as provided herein.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4750, 4751, 4753, 4753.5 and 4754.5, Labor Code.

HISTORY

1. Amendment filed 6-28-83; designated effective 7-1-83 pursuant to Government Code Section 11346.2(d) (Register 83, No. 27).

2. Amendment of last paragraph filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10942. Service.

Service of all documents directed to the Subsequent Injuries Fund shall be made on the Division of Workers' Compensation, Subsequent Injuries Fund.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4750, 4751, 4753, 4753.5 and 4754.5, Labor Code.

HISTORY

1. Amendment filed 6-28-83; designated effective 7-1-83 pursuant to Government Code Section 11346.2(d) (Register 83, No. 27).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10944. Notice of Hearing.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5502, Labor Code.

HISTORY

1. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10946. Medical Reports in Subsequent Injuries Benefits Trust Fund Cases.

When an application is filed against the Subsequent Injuries Benefits Trust Fund, any party who has previously filed medical reports shall forthwith serve copies on the Division of Workers' Compensation, Subsequent Injuries Benefits Trust Fund, and in no case later than thirty (30) days prior to the mandatory settlement conference or other hearing, unless service is waived by the Division of Workers' Compensation, Subsequent Injuries Benefits Trust Fund.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code.

HISTORY

1. Amendment filed 6-28-83; designated effective 7-1-83 pursuant to Government Code Section 11346.2(d) (Register 83, No. 27).

2. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

3. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10950. Petitions Appealing Orders Issued by the Administrative Director.

Except as provided in Rule 10953, petitions appealing orders issued by the Administrative Director shall be filed in accordance with the provisions of Article 9 (section 10290 et seq.) of the Rules of the Court Administrator. Where a workers' compensation judge has determined such an appeal, any aggrieved party may file a petition for reconsideration in accordance with the provisions of Labor Code section 5900 et seq. and Appeals Board Rules 10840 et seq.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 129, 4603, 4604, 5300, 5301 and 5302, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

2. Amendment of section heading, section and Note filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10952. Appeal of Notice of Compensation Due. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 129, 5300 and 5301, Labor Code.

HISTORY

1. New section filed 6-11-92 with Secretary of State by Workers' Compensation Appeals Board; operative 6-11-92. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 92, No. 24).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

3. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10953. Petition Appealing Audit Penalty Assessment-- Labor Code Section 129.5(g).

(a) An insurer, self-insured employer, or third-party administrator may appeal a civil penalty assessment issued pursuant to subdivision (g) of Labor Code section 129.5 by filing a petition with any district office or with the Appeals Board in San Francisco, in the same time and manner as provided by the Labor Code and Rule 10840 et seq. for the filing of a petition for reconsideration, except that a copy of the petition also shall be served on the Administrative Director. The petition shall be accompanied by a completed document cover sheet.

(b) The Administrative Director may answer the petition in the same time and manner provided for the filing of an answer to a petition for reconsideration.

(c) After the filing of a petition appealing a civil penalty assessment issued pursuant to Labor Code section 129.5(g), an adjudication case will be created and an adjudication case number will be assigned. The adjudication case number will be served by the Appeals Board on the Administrative Director and on the parties and attorneys listed on the proof of service to the petition.

(d) Within 15 days after the Administrative Director receives a copy of petition appealing a civil penalty assessment issued pursuant to Labor Code section 129.5(g), the Administrative Director shall submit to the Appeals Board in San Francisco a certified copy of the complete record of proceedings created by the Administrative Director in accordance with Article 6 of the Administrative Director's rules (Cal. Code Regs., tit. 8, § 10113 et seq.) The certified copy of the record shall include, but shall not necessarily be limited to: (1) the Order to Show Cause Re: Assessment of Civil Penalty and Notice of Hearing; (2) the Answer to the Order to Show Cause; (3) any amended complaint or supplemental Order to Show Cause that may have been issued, and any Amended Answer filed in response thereto; (4) any pre-hearing written statement filed by the claims administrator; (5) any pre-hearing Minutes and pre-hearing Orders; (6) the Minutes of any Hearing, a transcript or summary of any oral testimony offered at the hearing, any documentary evidence or affidavits offered at the hearing; and (7) the Administrative Director's written Determination and statement of the basis for the Determination. The original record of the proceedings conducted pursuant to Labor Code section 129.5(g) shall not be filed.

(e) The Appeals Board may scan the appeal, any answer, and the photocopied record of the Administrative Director's proceedings into the adjudication file within EAMS. Upon scanning, the paper documents may be destroyed.

(f) The Appeals Board shall determine the appeal using the record created by the Administrative Director in accordance with Article 6 of the Administrative Director's rules (Cal. Code Regs., tit. 8, § 10113 et seq.) The Administrative Director's record shall be deemed part of the Workers' Compensation Appeals Board's record of proceedings under section 10750.

Note: Authority cited: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Section 129.5(g), Labor Code.

HISTORY

1. New section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

2. Amendment of section and Note filed 11-17-2008; operative 11-17-2008.
Submitted to OAL for printing only (Register 2008, No. 47).

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§10955. Rehabilitation Appeals. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 139.5, 4645 and 5500, Labor Code.

HISTORY

1. Repealer and new section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

3. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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§10956. Rehabilitation Records.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 139.5, 5708 and 5709, Labor Code.

HISTORY

1. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10957. Deposition of Rehabilitation Consultants. [Repealed]

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5708, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003.
Submitted to OAL for printing only pursuant to Government Code section11351 (Register 2002, No. 51).

2. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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Article 20. Review of Administrative Orders

New query

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§10958. Hearing and Burden of Proof.

Proceedings instituted under Section 10955 shall be assigned, heard and determined in the same manner as proceedings instituted for the collection of other compensation except that the burden of proof shall be on the person disputing the finding or determination of the Rehabilitation Unit.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5708, Labor Code.

HISTORY

1. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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Article 21. General

New query

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§10960. Operative Effect of Rules 10300 through 10958.

Authority cited: Sections 133 and 5307, Labor Code. Reference: Statutes of 1989, Chapters 892 and 893; and Statutes of 1993, Chapter 121.

HISTORY

1. Repealer and new section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52). For prior history, see Register 90, No. 5.

2. Repealer of article 21 (sections 10960-10964) and section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10961. Operative Effect of Rules 10960 through 10999.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Statutes of 1989, Chapters 892 and 893; and Statutes of 1993, Chapter 121.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

4. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10962. Referees

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5502, subdivision (d), Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Repealer filed 10-21-96; operative 11-1-96. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 96, No. 43).

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Article 21. General

New query

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§10963. Administrative Director of the Division of Workers' Compensation.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 110 and 111, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10964. Office of Benefit Determination.

NOTE

Authority cited: Sections 133 and 5309, Labor Code. Reference: Section 124, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10965. Application for Adjudication. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5500, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Repealer filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10966. Declaration of Readiness to Proceed.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 134, 5500 and 5502, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

4. Amendment of section filed 6-11-92 with Secretary of State by Workers' Compensation Appeals Board; operative 6-11-92. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 92, No. 24).

5. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

6. Repealer of article 22 (sections 10966-10967) and section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10967. Objection to Declaration of Readiness to Proceed.

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 134, 5500 and 5502, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

4. Amendment filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

5. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10968. Answers. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5500, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Repealer filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10969. Procedural Requirements. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5500, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Repealer filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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§10973. Service by the Parties and Lien Claimants. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5316, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Repealer of article heading and section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10974. Service on Attorney or Agent. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5316, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Repealer filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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§10975. Proof of Service by Parties and Lien Claimants. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5316, Labor Code.

HISTORY

1. Repealer filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10976. Hearing. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5502 and 5709, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Repealer of article heading and section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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§10977. Notice of Hearing. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5504, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Repealer filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10978. Physicians' Reports as Evidence. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4620, 4628, 5703, 5708 and 5709, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

4. Repealer of article heading and section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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§10979. Physicians' Reports. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4620, 5500, 5703, 5708 and 5709, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

4. Repealer filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10980. Cross-Examination of Physicians. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Article XIV, Section 4, California Constitution; and Sections 4600 through 5709, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Repealer filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10984. Impartial Medical Examiners.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 122 and 139, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment of article heading filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

4. Repealer of article 23 (section 10984) filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10985. Disputes Regarding Labor Code Section 4600 Liens. (Repealed)

NOTE: Authority, Sections 133 and 5307, Labor Code. Reference: Section 4903.4, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Repealer of article heading and section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10986. Binding Arbitration for Lien Claim Disputes. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 4903.4, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Repealer filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10987. Pre-Application Attorney Fees.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 4903 and 4906, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment of article heading and section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

4. Repealer of article 24 (sections 10987-10987.3) and section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10987.1. Information Request Form.

NOTE

Authority cited: Sections 133, 5307, 5407 and 5401.7, Labor Code. Reference: Section 5401.5, Labor Code.

HISTORY

1. New section exempt from OAL review pursuant to Government Code section 11351, filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment of section filed 6-11-92 with Secretary of State by Workers' Compensation Appeals Board; operative 6-11-92. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 92, No. 24).

3. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10987.2. Information Response Form.

NOTE

Authority cited: Sections 133, 5307 and 5401.6, Labor Code. Reference: Section 5401.6, Labor Code.

HISTORY

1. New section exempt from OAL review pursuant to Government Code section 11351, filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

2. Amendment of section filed 6-11-92 with Secretary of State by Workers' Compensation Appeals Board; operative 6-11-92. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 92, No. 24).

3. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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§10987.3. Operative Effect of Rules 10987.1 and 10987.2.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 4903 and 4906, Labor Code; and Statutes of 1993, Chapter 121.

HISTORY

1. New section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

2. Repealer filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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New query

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§10988. Reconsideration of Arbitrators' Decisions or Awards. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5277(c), 5275(d), and 5900 through 5911, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

4. Repealer of article heading and section filed 12-23-93; operative 1-1-94. Submitted to OAL printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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§10989. Report of Arbitrator. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5275(c), 5275(d), and 5900 through 5911, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

4. Repealer filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10990. Reconsideration of Settlement Conference Referees' Decisions or Awards. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 111 and 5502, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

4. Repealer filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10991. Report of Settlement Conference Referee. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 111 and 5502, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

4. Repealer filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10992. Rehabilitation Appeals. (Repealed)

NOTE: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 139.5, 4645(d) and 5500, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code Section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Repealer of article heading and section filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

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New query

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§10995. Mandatory Arbitration. (Repealed)

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5270 through 5277, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code section11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment exempt from OAL review pursuant to Government Code section11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

4. Amendment of article heading filed 12-23-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 52).

5. Renumbering of former article 25 to article 22 and amendment of section filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

6. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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New query

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§10996. Voluntary Arbitration. (Repealed)

Note: Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5270 through 5277, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code section11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment exempt from OAL review pursuant to Government Code section11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

4. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

5. Repealer filed 11-17-2008; operative 11-17-2008. Submitted to OAL for printing only (Register 2008, No. 47).

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New query

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§10997. Request for Arbitration.

In no event will arbitration be permitted after the taking of testimony in any proceeding.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Sections 5270 through 5277, Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

4. Amendment filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 2. Workers' Compensation Appeals Board--Rules and Practice Procedure
Article 22. Arbitration

New query

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§10998. Disqualification of Arbitrator.

This rule applies to injuries occurring on or after January 1, 1990, except that this rule applies regardless of the date of injury for voluntary arbitration pursuant to Labor Code section 5275, subdivision (b).

After service of a list of panel members pursuant to rule 10995, any party may, within six (6) days, petition the workers' compensation judge to remove any member from the panel pursuant to section 170.1 of the Code of Civil Procedure. In event the presiding workers' compensation judge finds cause under section 170.1 of the Code of Civil Procedure, the presiding workers' compensation judge shall remove the member or members of the panel challenged and add to the original list the appropriate number of arbitrators at random to make a full panel and, within six (6) days, serve the list on the parties.

In event the presiding workers' compensation judge selects an arbitrator pursuant to rule 10995, the parties will have six (6) days after service of the name of the arbitrator to petition to disqualify that arbitrator pursuant to section 170.1 of the Code of Civil Procedure. If the presiding workers' compensation judge finds cause, the presiding workers' compensation judge shall assign another arbitrator pursuant to Labor Code section 5271, subdivision (d) and order the issue or issues in dispute submitted to that arbitrator.

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5271(d), Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

4. Amendment of first paragraph and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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Chapter 4.5. Division of Workers' Compensation
Subchapter 2. Workers' Compensation Appeals Board--Rules and Practice Procedure
Article 22. Arbitration

New query

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§10999. Arbitrator Fee and Cost Disputes.

Any dispute involving an arbitrator's fee or cost shall be resolved by the presiding workers' compensation judge of the appropriate local office or, in his or her absence, the acting presiding workers' compensation judge.

Any request to resolve a dispute about arbitrator fees or costs must be accompanied by any written agreement pertaining to arbitrator fees or costs and a statement that shall include the nature of the dispute and an itemization of the hours spent in actual arbitration hearing, in preparation for arbitration, and in preparation of the decision. The statement shall also include an itemization of the verifiable costs including use of facility, reporters and transcript preparation.

An arbitrator fee shall not exceed a reasonable amount. In establishing a reasonable fee, the Presiding Workers' Compensation Judge shall consider:

(a) responsibility assumed by the arbitrator;

(b) experience of the arbitrator;

(c) number and complexity of the issues being arbitrated;

(d) time involved; and

(e) expeditiousness and completeness of issue resolution.

The presiding workers' compensation judge of each local office shall maintain statistics on all arbitration fees awarded pursuant to Labor Code section 5273(c) including the amount thereof and rationale or basis for the award pursuant to (a) through (e) herein above.

Arbitration costs will be allowed in a reasonable amount pursuant to Labor Code section 5273, subdivision (a).

NOTE

Authority cited: Sections 133 and 5307, Labor Code. Reference: Section 5273(c), Labor Code.

HISTORY

1. New section filed 1-12-90; operative 1-12-90 (Register 90, No. 5). This section is exempt from review by OAL pursuant to Government Code section 11351.

2. Change without regulatory effect filed 1-26-90 (Register 90, No. 5).

3. Amendment exempt from OAL review pursuant to Government Code section 11351 filed 12-19-90; operative 1-1-91 (Register 91, No. 7).

4. Amendment of section and Note filed 12-19-2002; operative 1-1-2003. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 2002, No. 51).

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 1. Delegation of Enforcement Authority

New query

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§15550. Delegation of Enforcement Authority.

The Director of Industrial Relations delegates concurrent authority to enforce Labor Code Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727 to the Division of Labor Standards Enforcement.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

HISTORY

1. New Group 2.05 (Articles 1-15, Sections 15550-15596) filed 6-27-79; effective thirtieth day thereafter (Register 79, No. 26).

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 2. Definitions

New query

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§15551. Direction to File Verified Statement.

"Direction to File Verified Statement" means the notice sent pursuant to Labor Code Section 3722 to employers found by the Workers' Compensation Appeals Board not to have secured the payment of compensation.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 2. Definitions

New query

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§15552. Director.

"Director" means the Director of Industrial Relations or his designated agents or delegees.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 2. Definitions

New query

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§15553. Division.

"Division" means Division of Labor Standards Enforcement unless otherwise specified.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 2. Definitions

New query

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§15554. Findings.

"Findings" means Findings issued by the Division after a hearing on the objection to a Penalty Assessment Order or a Stop Order.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
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Article 2. Definitions

New query

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§15555. Issue.

"Issue" means to issue and serve a Stop Order, a Penalty Assessment Order or a Notice on the employer.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 2. Definitions

New query

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§15556. Notice of Findings on Penalty Assessment Order or Stop Order.

"Notice of Findings on Penalty Assessment Order or Stop Order" means the notice issued by the Division to an employer after a hearing on the objection to a Penalty Assessment Order or a Stop Order.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 2. Definitions

New query

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§15557. Penalty Assessment Order.

"Penalty Assessment Order" means an order issued by the Division to an employer requiring the payment of penalties as set forth in Labor Code Sections 3710.1, 3711 or 3722.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 2. Definitions

New query

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§15558. Special Judgment.

"Special Judgment" means the judgment entered by the clerk of the Superior Court pursuant to Labor Code Section 3726.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 2. Definitions

New query

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§15559. Stop Order.

"Stop Order" means an order issued by the Director pursuant to Labor Code Section 3710.1 to an employer prohibiting the use of employees' labor until the employer secures the payment of compensation as required by Labor Code Section 3700.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 2. Definitions

New query

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§15560. Uninsured Employer.

"Uninsured Employer" means any employer who has failed to secure the payment of compensation as required by Labor Code Section 3700.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 371, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 2. Definitions

New query

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§15561. Verified Statement.

"Verified Statement" means a written form sent by the Workers' Compensation Appeals Board to an employer upon which such employer is directed to indicate (under penalty of perjury) the number of employees in his employ on the date of injury and submit this statement to the Division.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 2. Definitions

New query

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§15562. Verified Petition.

"Verified Petition" means a written statement made and signed by an employer either (1) under oath taken before a notary public or other officer authorized to take affidavits and to administer oaths or (2) under a declaration stating in substance "I declare under penalty of perjury that the foregoing is true and correct" and further stating the date and place of execution. This petition is to be used by an employer who wishes to object to a Penalty Assessment Order and thereby request an administrative appeals.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 3. Investigation of Employer's Workers' Compensation Status

New query

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§15563. Access to Places of Labor.

The Division, its deputies and agents shall have free access to information about workers' compensation coverage in all places of labor. The Division shall investigate any employer to determine whether he has secured the payment of workers' compensation as required by law.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 3. Investigation of Employer's Workers' Compensation Status

New query

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§15564. Inquiry into Workers' Compensation Status.

The Division shall inquire of any employer the status of such employer's workers' compensation coverage pursuant to Section 3711 of the Labor Code.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 3. Investigation of Employer's Workers' Compensation Status

New query

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§15565. Posting Notice of Workers' Compensation Carrier.

Each employer is required to post a notice of his workers' compensation carrier at his headquarters or branch office together with the date of the expiration of his policy and the telephone number of the nearest office of the Labor Commissioner so that employees may call to report expiration of such coverage (as required by Labor Code Section 3713). Failure to post such notice is a misdemeanor.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 4. Penalties

New query

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§15566. Assessment of Penalty.

Insured employers shall be assessed penalties for the failure or refusal to furnish information concerning the status of their workers' compensation coverage. Uninsured employers shall be assessed penalties for the failure to secure the payment of workers' compensation coverage for their employees.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 4. Penalties

New query

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§15567. Penalty Assessment Orders.

Penalties shall be assessed by the issuance of Penalty Assessment Orders and shall be served as prescribed in these regulations.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 4. Penalties

New query

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§15568. Types of Penalty Assessment.

(a) Penalties in Non-Injury Cases.

(1) A fifty ($50) dollar penalty shall be assessed against an insured employer who fails or refuses to make a written response as to the status of his workers' compensation insurance when directed to do so by the Division.

(2) A one hundred ($100) dollar penalty shall be assessed an uninsured employer for each employee in his employ and not necessarily actually working at the time, a Stop Order is served upon him for failing to carry workers' compensation coverage on his employees.

(b) Penalties in Injury Cases.

(1) A one hundred ($100) dollar penalty per employee employed on the date of a claimed injury shall be assessed the employer where the Workers' Compensation Appeals Board finds (a) the employer was uninsured and (b) the injury was not compensable.

(2) A five hundred ($500) dollar penalty per employee employed on the date of injury shall be assessed an employer where the Workers' Compensation Appeals Board finds (a) the employer was uninsured and (b) the injury was compensable.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 4. Penalties

New query

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§15569. Maximum Penalties.

The maximum penalties that may be assessed under Section 15568(a)(2) and Section 15568(b)(1) and (b)(2) shall not exceed ten thousand ($10,000) dollars.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 4. Penalties

New query

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§15570. Number of Employees.

(a) Uninsured Employers in Non-Injury Cases. When issuing a one hundred ($100) dollar Penalty Assessment Order against an uninsured employer, the number of employees employed by such employer, and not necessarily those actually working at the time, in non-injury cases shall be ascertained by the Division at the time the Stop Order is served.

(b) Uninsured Employers in Injury Cases.

(1) After the issuance of a final decision of the Workers' Compensation Appeals Board, the Appeals Board shall mail to the uninsured employer and the Division a copy of the final decision and notice of the provisions of Labor Code Sections 3710.1 and 3722 which require such employer to pay penalties of one hundred ($100) dollars per employee and five hundred ($500) dollars per employee in non-compensable and compensable cases, respectively.

(2) In order to establish the number o employees, such employer shall submit to the Division within ten (10) days after service of the aforementioned documents by the Workers' Compensation Appeals Board, a verified statement of the number of employees in his employ on the date of injury.

(3) If such employer fails to submit to the Division a verified statement indicating the number of employees employed or if the Division disputes the accuracy of such verified statement, on the date of injury the Division shall issue a Penalty Assessment Order using such information regarding the number of such employees as the Division may have or otherwise obtain.

(4) Notice of the Penalty Assessment Order shall be mailed to the employer at his residence or usual place of business by registered or certified mail.

(5) The employer to whom the assessment is directed may file within twenty (20) days after receipt thereof a verified petition in writing, objecting to the assessment and setting forth the grounds for his objection.

(6) If such employer does not file a petition with the Division within said twenty (20) days, such assessment shall become conclusive and the amount thereof shall be due and payable from the employer so assessed to the Division for deposit in the State Treasury to the credit of the Uninsured Employers Fund.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 5. Stop Order

New query

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§15571. When Issued.

Where an employer is found to be without workers' compensation insurance as required by law, the Division shall issue and serve a Stop Order on such employer (1) prohibiting his use of employee labor until he acquires coverage and (2) requiring him to pay lost wages to his employees affected by the work stoppage, not exceeding ten (10) days' pay, pending compliance by such employer.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 5. Stop Order

New query

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§15571.5. When Effective.

A Stop Order shall be effective immediately upon service and shall remain in effect during any appeal proceedings, unless and until the employer acquires workers' compensation coverage.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 5. Stop Order

New query

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§15572. Failure to Observe Stop Order Constitutes Misdemeanor.

Such Stop Order shall inform the employer that failure to observe same constitutes a misdemeanor, and if the employer is convicted thereof, the court is required to impose a mandatory jail sentence in the county jail of not less than ten (10) days and a fine of not less than three hundred ($300) dollars.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 5. Stop Order

New query

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§15573. Injunctive Relief.

Where an uninsured employer fails to comply with a Stop Order, the Division may seek injunctive relief from the courts.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 6. Contents of Orders, of Direction to File Verified Statement and of Verified Statement

New query

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§15574. Stop Order.

The Stop Order issued and served on the uninsured employer pursuant to Labor Code Section 3710.1 shall contain the following information:

(a) The uninsured employer shall cease and desist the use of employee labor until he obtains the required workers' compensation coverage.

(b) Such employer shall be assessed a penalty of one hundred ($100) dollars per employee employed at the time the Stop Order is issued and served for failure to have obtained workers' compensation.

(c) The correct name and legal entity of the employer, the employer's address, the date, the time, the place of issuance, the signature and the name of the official who issues the Stop Order.

(d) The appeal procedure for objecting to a Stop Order.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 6. Contents of Orders, of Direction to File Verified Statement and of Verified Statement

New query

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§15575. Penalty Assessment Orders.

(a) $50 Penalty Assessment Order. This order, issued pursuant to Labor Code Section 3711 shall contain the following information:

(1) The employer has failed to furnish a written statement to the Division stating the name of his workers' compensation insurance carrier.

(2) Failure to furnish such statement within ten (10) days constitutes prima facie evidence of the employer's neglect or failure to comply with the coverage requirements of the law.

(3) The employer, by virtue of the Order, is assessed a penalty of fifty ($50) dollars for such failure.

(4) The correct name and legal entity of the employer, the employer's address, the date, the place of issuance, the signature and the name of the official who issues the order.

(5) The appeal procedure for objecting to this penalty assessment order.

(6) The procedure used by the Division to obtain a judgment against the employer, should he fail to pay the assessment.

(b) $100 Non-Injury Penalty Assessment Order. The order, issued pursuant to Labor Code Section 3710.1 shall contain the following information:

(1) The employer has been found to be without the required workers' compensation insurance.

(2) The employer, by virtue of the Order, is assessed a penalty of one hundred ($100) dollars per employee employed at the time the Order is issued for failure to have workers' compensation coverage.

(3) The correct name and legal entity of the employer, the employer's address, the date, the time, the place of issuance, the signature and the name of the official who issued the Order.

(4) The appeal procedure for objecting to the Penalty Assessment Order.

(5) The procedure used by the Division to obtain a judgment against the employer, should he fail to pay the assessment.

(c) $100 Injury-related Penalty Assessment Order. The order, issued pursuant to Labor Code Section 3710.1 shall contain the following information:

(1) The Workers' Compensation Appeals Board has found the employer to be uninsured in a claimed injury and that such injury is noncompensable.

(2) The employer, by virtue of the Order, is assessed a penalty of one hundred ($100) dollars employee employed on the date of such claimed injury.

(3) The correct name and legal entity of the employer, the employer's address, the date, the place of issuance, the signature and the name of the official who issued the Order.

(4) The appeal procedure for objecting to the Order.

(5) The procedure used by the Division to obtain a judgment against the employer, should he fail to pay the assessment.

(d) $500 Injury-related Penalty Assessment Order. The Order issued pursuant to Labor Code Section 3722 shall contain the following information:

(1) The Workers' Compensation Appeals Board has found the employer to be uninsured and the claimed injury compensable.

(2) The employer, by virtue of the Order, is assessed a penalty of five hundred ($500) dollars per employee employed on the date of injury.

(3) The correct name and legal entity of the employer, the employer's address, the date, the place of issuance, the signature and the name of the official who issued the Order.

(4) The appeal procedure for objecting to the Order.

(5) The procedure used by the Division to obtain a judgment against the employer, should he fail to pay the assessment.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 6. Contents of Orders, of Direction to File Verified Statement and of Verified Statement

New query

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§15576. Direction to File Verified Statement.

The statement, which shall be mailed to the employer by the Workers' Compensation Appeals Board simultaneously with the issuance and service of Findings of Fact, Findings and Order or Findings and Award, shall contain the following information:

(a) The Workers' Compensation Appeals Board has found the employer to be without the required workers' compensation coverage.

(b) The Division shall assess the employer a penalty of one hundred ($100) dollars or five hundred ($500) dollars per employee at the time of the injury pursuant to Labor Code Sections 3710.1 and 3722, respectively.

(c) The employer is requested to complete and submit to the Division within ten (10) days the verified statement on the reverse side of the Direction to File Verified Statement indicating the number of employees employed on the date of injury.

(d) The Division may dispute the accuracy of such verified statement.

(e) The Appeal procedure for objecting to the one hundred ($100) dollar injury-related Penalty Assessment Order (Labor Code Section 3710.1) and to the five hundred ($500) dollar injury-related Penalty Assessment Order (Labor Code Section 3722).

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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New query

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§15577. Verified Statement.

The verified statement, which shall be mailed to the employer by the Workers' Compensation Appeals Board simultaneously with the issuance of Findings of Fact, Findings and Order or Findings and Award, shall be found on the reverse side of the Direction to File Verified Statement and shall contain the following information:

(a) That the employer must complete the verified statement and submit the requested information to the Division.

(b) The number of employees in the employer's employ on the date of injury.

(c) A certification under penalty of perjury by the employer that such number is true and correct.

(d) The employer's signature, address and the date and place of execution thereof.

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Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 7. Service of Stop Order and Penalty Assessment Order

New query

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§15578. Service.

Any Stop Order or Penalty Assessment Order under the law and pursuant to these regulations issued to and served upon an employer may be served as follows:

(a) By delivering a copy of same to the employer if the employers is an individual;

(b) By delivering a copy of same to any general partner of the employer if the employer is a partnership;

(c) By delivering a copy of same to any person specified in Section 416.10 of the Code of Civil Procedure (specified corporate officers or designated agent) if the employer is a corporation;

(d) By any other manner authorized under the Code of Civil Procedure for the service of process in a civil action.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 8. Review of Proceedings and Withdrawal Proceedings

New query

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§15579. Review of Proceedings to Correct Designation of Legal Entity or Clerical Error.

(a) During an appeal hearing, a hearing officer may establish the correct legal entity of the employer and may amend any necessary documents to reflect said true legal entity.

(b) The Division may correct a clerical error where such error has been made in an order, or decision until it becomes final to conform with the facts and the intended wording.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 8. Review of Proceedings and Withdrawal Proceedings

New query

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§15580. Withdrawal of Orders.

The Division may withdraw a Stop Order or a Penalty Assessment Order:

(a) Where investigation indicates the employer had secured the payment of compensation as required by Section 3700 of the Labor Code at the time of service of such Orders; or

(b) Where an insured employer responded in writing within the prescribed time to a request to furnish the status of his workers' compensation coverage; or

(c) Where investigation indicates the employer had no employees.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 9. Appeal Procedures

New query

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§15581. Stop Order.

Where an employer objects to a Stop Order and desires a hearing thereon, such employer may make an oral or written request for a hearing. Upon receipt of such request, the Division shall set the matter for a hearing within five (5) days from the date of receipt thereof.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 9. Appeal Procedures

New query

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§15582. Penalty Assessment Orders.

An employer may object to a Penalty Assessment Order within twenty (20) days after the service of the Order by filing a verified petition objecting to said Penalty Assessment Order and setting forth the ground(s) for such objections which are as set forth in Section 15584 of this Article. Upon the filing of such petition within the time prescribed, the Division shall set the matter for hearing within thirty (30) days thereafter.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 9. Appeal Procedures

New query

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§15583. Grounds of Objection.

The grounds of objection are as follows:

(a) The Division acted without or in excess of its jurisdiction;

(b) The Stop Order, Penalty Assessment Orders, or Notice were not properly served;

(c) The correct legal entity is not set forth in the Order or Notice.

(d) The employer was legally insured for workers' compensation;

(e) No employment relationship exists between the worker and the person assessed or enjoined;

(f) The Division committed mistake, error or omission; or

(g) The Division acted arbitrarily, capriciously and in abuse of its discretion.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 9. Appeal Procedures

New query

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§15584. Matters Not Grounds for Objection.

The following reasons which may be asserted are not sufficient or valid grounds for objection:

(a) Ignorance of the law;

(b) The employer's assertion that the workers' compensation insurance premiums are excessive; or

(c) The employer's mistaken belief that he had such insurance.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 10. Hearing

New query

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§15585. Proceedings Under Oath.

All testimony adduced at the hearing shall be taken under oath. The hearing officer shall administer such oath.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 10. Hearing

New query

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§15586. Proceedings Shall Be Recorded.

Any proceedings heard before the Division shall be recorded.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 10. Hearing

New query

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§15587. Conduct of Hearing.

Any Party to the hearing is entitled to be heard, to present evidence and to cross examine witnesses appearing at the hearing, but the Division is not bound by common law or statutory rules of evidence or procedure.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 10. Hearing

New query

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§15588. Right to Subpoenas and Subpoenas Duces Tecum

(a) Subpoenas.

Upon request of any party to a hearing on a Penalty Assessment Order or Stop Order, the Division may issue subpoenas for the attendance of witnesses before the Division at the time and place of hearing. Said subpoenas shall be served in the manner provided for serving subpoenas in civil actions. The Division shall not issue subpoenas in blank.

(b) Subpoenas Duces Tecum.

Upon the request of any party to a hearing on a Penalty Assessment Order or Stop Order, accompanied by a declaration of materiality thereof in the manner provided for in Section 1985 of the Code of Civil Procedure, the Division may issue subpoenas duces tecum requiring witnesses or parties to produce any books, documents or other materials under their control which they are bound by law to produce at the time and place of hearing. Subpoenas duces tecum served hereunder shall be served as provided therefor in civil actions.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 10. Hearing

New query

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§15589. Custody of Papers Filed with the Division.

Books, documents and other materials admitted into evidence may be withdrawn only on condition that an exact copy of any such books, documents or other materials sought to be removed, be offered in evidence in lieu thereof. In such event, there shall be made on the face of any such copy so admitted, a notation that the same is identical to the original withdrawn, and such notation shall be dated and signed by both the employer and the hearing officer.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Article 10. Hearing

New query

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§15590. Decision of the Division.

(a) Stop Order. At the conclusion of a hearing on a Stop Order, the Division shall immediately affirm or dismiss said Stop Order. In addition, the Division shall issue and serve on any party to the hearing by registered or certified mail a written Notice of Findings and Findings within twenty-four (24) hours after the conclusion of such hearing.

(b) Penalty Assessment Order. The decision of the Division on any Penalty Assessment Order shall consist of Notice of Findings and written Findings which shall be served on any party to the hearing by registered or certified mail within fifteen (15) days after said hearing.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
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Article 11. Writ of Review

New query

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§15591. Employer's Right to Writ of Review.

An employer, upon receipt of Findings affirming or modifying any Penalty Assessment Order may file a Writ of Review from any such Findings to the appropriate superior court upon the execution by such employer of a bond to the State in double the amount so found due and ordered paid by such employer conditioned that such employer will pay any judgment and costs rendered against him for such assessment.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
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Article 12. Special Judgment Procedure As to Penalty Assessment Orders

New query

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§15592. Procedures After Hearing or in the Absence of a Hearing.

(a) Where a hearing has been held and Notice of Findings and Findings have been issued and served on the uninsured employer, and after ten (10) days have expired since the issuance and service thereof, certified copies of the Penalty Assessment Order and the Findings shall be filed with the Judgment (Special) for the Uninsured Employers Fund with the clerk of the superior court who shall enter a judgment in favor of the Director of Industrial Relations as Administrator of the Uninsured Employers Fund, and against the uninsured employer in the amount shown on the Findings unless a Writ of Review has been filed within the said ten (10)-day period.

(b) Where a petition objecting to a Penalty Assessment Order has not been filed, a hearing has not been held and twenty (20) days have expired since the issuance and service of the Penalty Assessment Order, a certified copy of the Penalty Assessment Order may be filed with the Judgment (Special) for the Uninsured Employers Fund with the clerk of the superior court who shall enter a judgment in favor of the Director of Industrial Relations, as Administrator of the Uninsured Employers Fund, and against the uninsured employer in the amount shown on the assessment order.

(c) Upon the entry of a Special Judgment by the clerk of the superior court under Section 15592 (a) and (b) a Notice of Entry of Judgment (Special) for the Uninsured Employers Fund shall be filed and served upon the employer by regular first-class mail.

(d) After full payment has been made of a Judgment (Special) for the Uninsured Employers Fund, an Acknowledgment of Full Satisfaction of Judgment may be filed with the clerk of the superior court.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 12. Special Judgment Procedure As to Penalty Assessment Orders

New query

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§15593. Procedures Subsequent to Entry of Judgment.

After a Judgment (Special) has been entered and Notice of Entry of such Judgment has been mailed to the employer and he has failed or refused to pay such judgment, the Division may obtain a writ of execution thereon.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 14. Penalty Liens

New query

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§15594. Recording of Penalty Lien.

Where the employer has failed to secure the payment of compensation, the Division shall file with the county recorder of any county in which such employer's property may be located, a certificate of the amount of penalty due from such employer and such amount shall be a lien in favor of the Division from the date of such filing against the real property and personal property of the employer within the county in which such certificate is filed in accordance with Labor Code Section 3727.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 14. Penalty Liens

New query

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§15595. Cancellation of Penalty Lien.

Upon payment of the penalty assessment and upon the employer's request, the Division shall issue a certificate of cancellation of penalty assessment which may be recorded by the employer at his expense.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.05. Enforcement of Workers' Compensation Coverage, Penalty Assessment Orders, Stop Orders and Posting and Notice Requirements
Article 15. Notice of Right to Benefits

New query

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§15596. Notice of Employee's Right to Workers' Compensation Benefits.

(a) Employers shall notify, orally or in writing, every new employee, either at the time the employee is hired or by the end of his first pay period, of the employee's right to receive workers' compensation benefits should he be injured on the job at any time while in such employer's employ.

(b) Employers who need not give such notice are owners or occupants of residential dwellings whose employees perform duties which are incidental to the ownership, maintenance or use of the dwelling, including the care and supervision of children or whose duties are personal and not in the course of the trade, business, profession or occupation of such owner or occupant if such employees are employed for less than fifty-two (52) hours during a ninety (90)-day period and earn less than one hundred ($100) dollars.

NOTE: Authority cited: Sections 55 and 3710, Labor Code. Reference: Sections 3700, 3710, 3710.1, 3710.2, 3711, 3712, 3713, 3714, 3718, 3722, 3723, 3725, 3726 and 3727, Labor Code.

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Chapter 8. Office of the Director
Subchapter 2.06. Workers' Compensation-Administration Revolving Fund Assessment, Uninsured Employers Benefits Trust Fund Assessment, Subsequent Injuries Benefits Trust Fund Assessments, Fraud Surcharge and Cal-OSHA Targeted Inspection Assessment

Article 1. Definitions

New query

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§15600. Definitions.

(a) Assessable Premium. The premium to which the assessment and/or surcharge is to be applied is the premium the insured is charged after all rating adjustments (experience rating, schedule rating, premium discounts, expense constants, retrospective rating, etc.) except for adjustments resulting from the application of deductible plans or the return of policyholder dividends.

(b) Assessment.Includes those assessments levied upon insured and self-insured employers to establish and maintain the Workers' Compensation Administration Revolving Fund, the Uninsured Employers Benefits Trust Fund, the Labor Enforcement and Compliance Fund, the Occupational Safety and Health Fund, and the Subsequent Injuries Benefits Employers Trust Fund.

(c) Base Year.For purposes of calculating the self-insured employer assessment factors, that time period as provided by the Office of Self-Insurance Plans pursuant to section 15602. For public self-insured employers, the base year is a fiscal year basis. For private self-insured employers, the base year is a calendar year basis.

(d)Director.The Director of the Department of Industrial Relations.

(e)Expected total current year premium.Total direct workers' compensation premium of all insurers as reported to the Department of Insurance's designated licensed rating organization for the period of January 1 through June 30 of the year immediately preceding the assessment, and adjusted by the Department of Insurance's designated licensed rating organization, to a full year basis.

(f) Indemnity.The payments made by a self-insured employer directly to injured employees or their dependents as compensation pursuant to Labor Code divisions 4 and 4.5 including vocational rehabilitation maintenance and salary continuation payments pursuant to Labor Code sections 4800 and 4850.

(g)Inception date.The inception date of a workers' compensation insurance policy is the normal anniversary rating date of a workers' compensation insurance policy as defined in the California Workers' Compensation Insurance Manual published by the Workers' Compensation Insurance Rating Bureau.

(h)Insured employer.Any employer, including any agency or division of the State of California, who secures workers' compensation insurance coverage under provisions of subdivision (a) of Labor Code section 3700.

(i)Insurer.Any person, including the State Compensation Insurance Fund, authorized to transact workers' compensation insurance in California.

(j) Labor Enforcement and Compliance Fund. The Labor Enforcement and Compliance Fund established pursuant to the provisions of Labor Code section 62.5.

(k) Labor Enforcement and Compliance Fund Assessment. The user fee assessment levied upon insured and self-insured employers to establish and maintain the Labor Enforcement and Compliance Fund.

(l) Occupational Safety and Health Fund. The Occupational Safety and Health Fund established pursuant to the provisions of Labor Code section 62.5.

(m) Occupational Safety and Health Fund Assessment. The user fee assessment levied upon insured and self-insured employers to establish and maintain the Occupational Safety and Health Fund.

(n) Payroll.Remunerationsubject to workers' compensation insurance premium for insured employers and that remuneration to employees of a self-insured employer which would be subject to premium charges if the employer were an insured employer.

(o) Revolving Fund. The Workers' Compensation Administration Revolving Fund established pursuant to the provisions of Labor Code section 62.5.

(p) Revolving Fund Assessment. The user fee assessment levied upon insured and self-insured employers to establish and maintain the Workers' Compensation Administration Revolving Fund.

(q) Self-insured employer. Any employer who is authorized by the Director to self-insure its workers' compensation liability under subdivisions (b) or (c) of Labor Code section 3700. A self-insured employer shall include the State of California. For the limited purposes of the Targeted Inspection Assessment, the term “self-insured employer” shall not include the State of California or a public agency employer.

(r) Subsequent Injuries Fund. The Subsequent Injuries Benefits Trust Fund established pursuant to the provisions of Labor Code section 62.5.

(s) Subsequent Injuries Fund Assessment. The user fee assessment levied upon insured and self-insured employers to establish and maintain the Subsequent Injuries Benefits Trust Fund.

(t)Surcharge.Surcharge means the “State Fraud Investigation and Prosecution Surcharge” assessed under authority of Labor Code Section 62.6.

(u) Targeted Inspection Assessment. The user fee assessment levied upon self-insured employers to establish and maintain the Cal-OSHA Targeted Inspection and Consultation Fund established pursuant to the provisions of Labor Code section 62.7.

(v) Uninsured Employers Fund. The Uninsured Employers Benefits Trust Fund established pursuant to the provisions of Labor Code section 62.5.

(w) Uninsured Employers Fund Assessment. The user fee assessment levied upon insured and self-insured employers to establish and maintain the Uninsured Employers Benefits Trust Fund.

Note: Authority cited: Sections 54, 55 and 62.5, Labor Code;and Section 1872.83, Insurance Code. Reference: Sections 51, 62.5, 62.6, 3700 and 3701, Labor Code; Section 1872.83, Insurance Code.

HISTORY

1. New section filed 4-18-90 as an emergency; operative 4-18-90 (Register 90, No. 18). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 8-16-90.

2. Certificate of Compliance as to 4-18-90 order including amendment adding subsections (c) and (k) and renumbering existing subsections transmitted to OAL 8-14-90 and filed 9-13-90 (Register 90, No. 43).

3. Amendment of article heading, amendment of subsections (a), (b) and (g), new subsection (l), and amendment of Note filed 1-15-93 as an emergency; operative 1-15-93 (Register 93, No. 3). A Certificate of Compliance must be transmitted to OAL 5-17-93 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 1-15-93 order including repealer of subsection (b), subsection relettering, and amendment of newly designated subsection (f) transmitted to OAL 5-10-93 and filed 6-16-93 (Register 93, No. 25).

5. Amendment of subchapter heading and subsection (b), new subsection (e) and subsection redesignation, amendment of subsections (f) and (l), new subsection (m) and amendment of Note filed 9-6-94 as an emergency; operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9-6-94 order including amendment of subsection (a), new subsection (j), subsection relettering and amendment of subsection (k) transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

7. Amendment of subsection (a), new subsection (d), repealer of subsection (n), subsection relettering and amendment of Note filed 11-14-95 as an emergency; operative 12-1-95 (Register 95, No. 46). A Certificate of Compliance must be transmitted to OAL by 3-30-96 or emergency language will be repealed by operation of law on the following day.

8. Certificate of Compliance as to 11-14-95 order transmitted to OAL 3-29-96 and filed 5-8-96 (Register 96, No. 19).

9. New subsection (a), repealer of subsection (m), and subsection relettering filed 11-10-97; operative 11-10-97 pursuant to Government Code section 11343.4(d) (Register 97, No. 46).

10. Change without regulatory effect amending subchapter heading and subsections (a) and (b), repealing subsections (k) and (l), relettering subsections and amending Note filed 12-15-99 pursuant to section 100, title 1, California Code of Regulations (Register 99, No. 51).

11. Amendment of subchapter heading, amendment of subsections (a) and (b), new subsections (k) and (l), subsection relettering, and amendment of Note filed 1-14-2000 as an emergency; operative 1-14-2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-15-2000 or emergency language will be repealed by operation of law on the following day.

12. Certificate of Compliance as to 1-14-2000 order transmitted to OAL 5-9-2000 and filed 6-15-2000 (Register 2000, No. 24).

13. Amendment of subchapter heading and subsections (b), (c) and (k), new subsections (n), (o) and (q)-(s) and subsection relettering filed 12-18-2003; operative 12-18-2003. Submitted to OAL for printing only (Register 2003, No. 51).

14. Amendment of subchapter heading and subsection (b), new subsections (j)-(k) and subsection relettering filed 11-12-2008; operative 11-12-2008. Submitted to OAL for printing only (Register 2008, No. 46).

15. Amendment of subchapter heading and subsection (b), new subsections (j)-(k) and subsection relettering filed 11-19-2009; operative 11-19-2009. Submitted to OAL for printing only (Register 2009, No. 47).

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Chapter 8. Office of the Director Subchapter 2.06. Workers' Compensation-Administration Revolving Fund Assessment, Uninsured Employers Benefits Trust Fund Assessment, Subsequent Injuries Benefits Trust Fund Assessments, Fraud Surcharge and Cal-OSHA Targeted Inspection Assessment Article 2. Determination of Assessments and/or Surcharge

New query

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§15601. Determination of Revolving Fund, Subsequent Injuries Fund, and Uninsured Employers Fund Total Assessment.

On or before November 1 of each year, the Director shall, in accordance with Labor Code Section 62.5:
(a) Determine the total amount of funds appropriated for the Division of Workers' Compensation;

(b) Determine the aggregate amount of the assessment for the Subsequent Injuries Fund;

(c) Determine the aggregate amount of the assessment for the Labor Enforcement and Compliance Fund;

(d) Determine the aggregate amount of the assessment for the Occupational Safety and Health Fund; and

(e) Determine the aggregate amount of the assessment for the Uninsured Employers Fund.

Note: Authority cited: Sections 54, 55 and 62.5, Labor Code. Reference: Section 62.5, Labor Code.

HISTORY

1. New section filed 4-18-90 as an emergency; operative 4-18-90 (Register 90, No. 18). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 8-16-90.

2. Certificate of Compliance as to 4-18-90 order transmitted to OAL 8-14-90 and filed 9-13-90 (Register 90, No. 43).

3. New article 2 heading, amendment of section heading, amendment of subsection (a) and repealer of subsection (b) filed 1-15-93 as an emergency; operative 1-15-93 (Register 93, No. 3). A Certificate of Compliance must be transmitted to OAL 5-17-93 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 1-15-93 order transmitted to OAL 5-10-93 and filed 6-16-93 (Register 93, No. 25).

5. Amendment of article heading, section and Note filed 9-6-94 as an emergency;

operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9-6-94 order including amendment of Note transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

7. Change without regulatory effect repealing section filed 12-15-99 pursuant to section 100, title 1, California Code of Regulations (Register 99, No. 51).

8. New section filed 1-14-2000 as an emergency; operative 1-14-2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-15-2000 or emergency language will be repealed by operation of law on the following day.

9. Certificate of Compliance as to 1-14-2000 order transmitted to OAL 5-9-2000 and filed 6-15-2000 (Register 2000, No. 24).

10. Amendment of section heading and section filed 12-18-2003; operative 12-18-2003. Submitted to OAL for printing only (Register 2003, No. 51).

11. Amendment of section heading and subsection (b), new subsection (c) and subsection relettering filed 11-12-2008; operative 11-12-2008. Submitted to OAL for printing only (Register 2008, No. 46).

12. Amendment of section heading, new subsection (c) and subsection relettering filed 11-19-2009; operative 11-19-2009. Submitted to OAL for printing only (Register 2009, No. 47).

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Chapter 8. Office of the Director
Subchapter 2.06. Workers' Compensation-Administration Revolving Fund Assessment, Uninsured Employers Benefits Trust Fund Assessment, Subsequent Injuries Benefits Trust Fund Assessments, Fraud Surcharge and Cal-OSHA Targeted Inspection Assessment

Article 2. Determination of Assessments and/or Surcharge

New query

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§15601.5. Collection of the Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Uninsured Employers Fund Assessment, and Fraud Surcharge from Self-Insured Employers.

On or before September 1 of each year, the Director shall ascertain from the Fraud Assessment Commission the aggregate amount of the surcharge to be assessed.

The aggregate amount of the surcharge shall be allocated between insured and self-insured employers by applying the same proportional allocation and collection methodology as used to collect the Workers' Compensation Administration Revolving Fund Assessment.

NOTE: Authority cited: Sections 54 and 55, Labor Code. Reference: Section 62.6, Labor Code.

HISTORY

1. New section filed 1-15-93 as an emergency; operative 1-15-93 (Register 93, No. 3). A Certificate of Compliance must be transmitted to OAL 5-17-93 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-15-93 order transmitted to OAL 5-10-93 and filed 6-16-93 (Register 93, No. 25).

3. Amendment of Note filed 9-6-94 as an emergency; operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 9-6-94 order including amendment of Note transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

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Article 2. Determination of Assessments and/or Surcharge

New query

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§15601.6. Determination of Targeted Inspection Assessment.

NOTE

Authority cited: Sections 54, 55, 62.5, 62.6 and 62.7, Labor Code. Reference: Section 62.7, Labor Code.

HISTORY

1. New section filed 9-6-94 as an emergency; operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 9-6-94 order including amendment of subsections (b)-(c) and repealer of subsection (d) transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

3. Repealer filed 11-14-95 as an emergency; operative 12-1-95 (Register 95, No. 46). A Certificate of Compliance must be transmitted to OAL by 3-30-96 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 11-14-95 order transmitted to OAL 3-29-96 and filed 5-8-96 (Register 96, No. 19).

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Article 2. Determination of Assessments and/or Surcharge

New query

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§15601.7. Determination of Self Insured Employers Subject to the Targeted Inspection Assessment.

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§ 15601.7. Determination of Self Insured Employers Subject to the Targeted Inspection Assessment.

On or before September 1 of each year, the Manager of Self-Insurance Plans shall identify for the Director each Private Self Insurer subject to the Targeted Inspection Assessment as determined below.
(a) The Targeted Inspection Assessment shall apply to each Self Insurer in each grouping set forth in subsection (b) that has a current 1-year average number of indemnity claims per 100 employees as calculated in subsection (e) below, that is equal to or in excess of 125 percent of the 3 year base figure determined for each grouping in subsection (d) of this section.

(b) The Manager shall categorize all private self insurers into groups for the purpose of calculating the Targeted Inspection Assessment. All private self insurers shall be categorized into groups by the first two digits of their North American Industry Classification System Code (NAICS Code) as reported on Page 1 of the Self Insurer's Annual Report for the reporting period immediately prior to the current budget year. For purposes of such categorization, each private group self insurer shall be considered as a single entity. The Manager may correct the NAICS Code reported for cause or where the Manager believes an error was made by the self insurer in designating their NAICS Code on the Annual Report. The Manager may also substitute the proper NAICS Code for the Standard Industrial Classification Code (SIC Code) if the SIC Code was reported rather than the NAICS Code.

(c) For each NAICS Code grouping set forth in subsection (a), the Manager shall calculate the historical average number of indemnity claims per 100 employees from the Consolidated Liabilities page of the full year Self Insurer's Annual Reports submitted by the members in each NAICS Code group for the 3 year reporting period immediately prior to the current 1-year period used to calculate the individual self insurer's indemnity claims per 100 employees.

(d) The Manager shall calculate a figure that will be 125 percent of each NAICS Code grouping's 3 year historical average number of indemnity claims per 100 employees.

(e) For each private self insurer, the Manager shall calculate an individual 1- year number of indemnity claims per 100 employees, using information reported by each self insurer on its last full year Self Insurer's Annual Report submitted for the reporting period immediately prior to the current budget year. In this calculation, the manager shall divide the total number of indemnity claims reported in the most recent claim year by the total number of California employees reported, with the result multiplied by 100. Any self insurer with less than 100 total employees shall be considered to have 100 employees for purposes of this calculation.

Note: Authority cited: Sections 54, 55, 62.7 and 62.9, Labor Code. Reference: Section 62.7 and 62.9, Labor Code.

HISTORY

1. New section filed 9-6-94 as an emergency; operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 9-6-94 order including amendment of first paragraph and subsections (a), (d), and (e), repealer of subsections (b)-(b)(3), and new subsection (b) transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

3. Amendment of section and Note filed 11-10-97; operative 11-10-97 pursuant to Government Code section 11343.4(d) (Register 97, No. 46).

4. Amendment of subsection (b) filed 12-18-2003; operative 12-18-2003. Submitted to OAL for printing only (Register 2003, No. 51).

5. Amendment of subsections (a)-(c) filed 3-2-2009; operative 3-2-2009 pursuant to Government Code section 11343.4 (Register 2009, No. 10).

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Article 2. Determination of Assessments and/or Surcharge

New query

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§15601.8. Determination of Insured Employers' Payroll and Premium Data.

On or before September 1 of each year, the Director shall request that the Department of Insurance direct the designated licensed rating organization to provide the Director with a statement for each insurer authorized to transact workers' compensation insurance in the state of California showing the total payroll and premium generated by that insurer on policies subject to an experience modification of 1.25 or more for the most recent policy year available.

NOTE

Authority cited: Sections 54, 55 and 62.7, Labor Code. Reference: Section 62.7, Labor Code.

HISTORY

1. New section filed 9-6-94 as an emergency; operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 9-6-94 order including amendment of section transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

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New query

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§15602. Allocation of Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Uninsured Employers Fund Assessment, and/or Fraud Surcharge Among Insured and Self-Insured Employers.

(a) Not later than November 1 of each year, the Director shall determine the proportional payroll allocation factors to use to determine the total insured employer Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Labor Enforcement and Compliance Fund Assessment, Occupational Safety and Health Fund Assessment, Uninsured Employers Fund Assessment, and Fraud Surcharge, and the total self-insured employer Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Labor Enforcement and Compliance Fund Assessment, Occupational Safety and Health Fund Assessment, Uninsured Employers Fund Assessment, and Fraud Surcharge as follows:

(1) The aggregate payroll of all insured employers shall be determined from payroll information provided by the Department of Insurance's designated licensed rating organization for the most recent period available.

(2) The aggregate payroll of all self-insured employers shall be determined from payroll information provided by the Office of Self-Insurance Plans of the Department of Industrial Relations excluding payroll of insured employees of the State of California for the most recent base year available.

(3) The total payroll information shall then be determined by combining the most recent insured employer payroll with the most recent self-insured employer payroll.
(4) The insured employer proportional payroll allocation factor shall be determined by dividing the insured employer payroll by the total combined payroll.

(5) The self-insured employer proportional payroll allocation factor shall be determined by dividing the self-insured employer payroll by the total combined payroll. The self-insured employer payroll shall not include that portion of the State of California's payroll which was covered by a policy of insurance.

(b) The total insured employer Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Labor Enforcement and Compliance Fund Assessment, Occupational Safety and Health Fund Assessment, Uninsured Employers Fund Assessment, and/or Fraud Surcharge shall be determined by multiplying each respective assessment and/or surcharge by the insured employer proportional payroll allocation factor.

(c) The total self-insured employer Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Labor Enforcement and Compliance Fund Assessment, Occupational Safety and Health Fund Assessment, Uninsured Employers Fund Assessment, and/or Fraud Surcharge shall be determined by multiplying each respective assessment and/or surcharge by the self-insured employer proportional payroll allocation factor.

Note: Authority cited: Sections 54, 55, 62.5 and 62.6, Labor Code. Reference: Sections 62.5 and 62.6, Labor Code.

HISTORY

1. New section filed 4-18-90 as an emergency; operative 4-18-90 (Register 90, No. 18). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 8-16-90.

2. Certificate of Compliance as to 4-18-90 order including amendment to subsection (a) transmitted to OAL 8-14-90 and filed 9-13-90 (Register 90, No. 43).

3. Amendment of section heading, section and Note filed 1-15-93 as an emergency; operative 1-15-93 (Register 93, No. 3). A Certificate of Compliance must be transmitted to OAL 5-17-93 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 1-15-93 order including amendment of subsection (a)(2) transmitted to OAL 5-10-93 and filed 6-16-93 (Register 93, No. 25).

5. Amendment of subsections (a)(1) and (3) and Note filed 9-6-94 as an emergency; operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9-6-94 order including amendment of section heading, subsections (a)-(a)(2), (b), (c) and Note transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

7. Change without regulatory effect amending section heading, section and Note filed 12-15-99 pursuant to
section 100, title 1, California Code ofRegulations (Register 99, No. 51).

8. Amendment of section heading, section and Note filed 1-14-2000 as an emergency; operative 1-14-2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-15-2000 or emergency language will be repealed by operation of law on the following day.

9. Certificate of Compliance as to 1-14-2000 order transmitted to OAL 5-9-2000 and filed 6-15-2000 (Register 2000, No. 24).

10. Amendment of section heading and section filed 12-18-2003; operative 12-18-2003. Submitted to OAL for printing only (Register 2003, No. 51).

11. Amendment of section heading and subsections (a), (b) and (c) filed 11-12-2008; operative 11-12-2008. Submitted to OAL for printing only (Register 2008, No. 46).

12. Amendment of section heading and subsections (a), (b) and (c) filed 11-19-2009; operative 11-19-2009. Submitted to OAL for printing only (Register 2009, No. 47).

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New query

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§15603. Determination of Insured and Self-Insured Employer Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Uninsured Employers Fund Assessment, and Fraud Surcharge Factors.

(a) The insured employer Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Labor Enforcement and Compliance Fund Assessment, Occupational Safety and Health Fund Assessment, Uninsured Employers Fund Assessment, and Fraud Surcharge factors shall be determined by dividing the total amount of each respective insured employer assessment and the total amount of the insured employer surcharge, as the case may be, by the expected total current year premium, as determined by the Department of Insurance's designated licensed rating organization.

(b) The self-insured employer Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Labor Enforcement and Compliance Fund Assessment, Occupational Safety and Health Fund Assessment, Uninsured Employers Fund Assessment, and/or Fraud Surcharge factors shall be determined by dividing the total amount of each respective self-insured employer assessment or surcharge, as the case may be, by the total amount of workers' compensation indemnity paid under California law by all self-insured employers during the most recent base year available, as determined by the Office of Self-Insurance Plans.

Note: Authority cited: Sections 54, 55 and 62.5, Labor Code. Reference: Sections 62.5 and 62.6, Labor Code.

HISTORY

1. New section filed 4-18-90 as an emergency; operative 4-18-90 (Register 90, No. 18). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 8-16-90.

2. Certificate of Compliance as to 4-18-90 order including amendment to subsection (b) transmitted to OAL 8-14-90 and filed 9-13-90 (Register 90, No. 43).

3. Amendment of section and Note filed 1-15-93 as an emergency; operative 1-15-93 (Register 93, No. 3). A Certificate of Compliance must be transmitted to OAL 5-17-93 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 1-15-93 order including amendment of

section (a)(2) transmitted to OAL 5-10-93 and filed 6-16-93 (Register 93, No. 25).

5. Amendment of section heading and text filed 9-6-94 as an emergency; operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9-6-94 order transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

7. Amendment of subsection (a) filed 11-14-95 as an emergency; operative 12-1-95 (Register 95, No. 46). A Certificate of Compliance must be transmitted to OAL by 3-30-96 or emergency language will be repealed by operation of law on the following day.

8. Certificate of Compliance as to 11-14-95 order transmitted to OAL 3-29-96 and filed 5-8-96 (Register 96, No. 19).

9. Change without regulatory effect amending section heading, section and Note filed 12-15-99 pursuant to
section 100, title 1, California Code ofRegulations (Register 99, No. 51).

10. Amendment of section heading, section and Note filed 1-14-2000 as an emergency; operative 1-14-2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-15-2000 or emergency language will be repealed by operation of law on the following day.

11. Certificate of Compliance as to 1-14-2000 order transmitted to OAL 5-9-2000 and filed 6-15-2000 (Register 2000, No. 24).

12. Amendment of section heading and section filed 12-18-2003; operative 12-18-2003. Submitted to OAL for printing only (Register 2003, No. 51).

13. Amendment of section heading and section filed 11-12-2008; operative 11-12-2008. Submitted to OAL for printing only (Register 2008, No. 46).

14. Amendment of section heading and section filed 11-19-2009; operative 11-19-2009. Submitted to OAL for printing only (Register 2009, No. 47).

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Article 2. Determination of Assessments and/or Surcharge

New query

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§15603.5. Determination of Targeted Inspection and Consultation Assessment Factors.

NOTE: Authority cited: Sections 54, 55 and 62.7, Labor Code. Reference: Section 62.7, Labor Code.

HISTORY

1. New section filed 9-6-94 as an emergency; operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 9-6-94 order including amendment of section and Note transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

3. Repealer filed 11-14-95 as an emergency; operative 12-1-95 (Register 95, No. 46). A Certificate of Compliance must be transmitted to OAL by 3-30-96 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 11-14-95 order transmitted to OAL 3-29-96 and filed 5-8-96 (Register 96, No. 19).

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New query

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§15604. Surplus in Funding.

(a) In the event of an unexpended surplus in the Workers' Compensation Administration Revolving Fund balance for a fiscal year, the balance shall be carried forward and credited to the subsequent year's Revolving Fund assessment.
(b) In the event of an unexpended surplus in the Subsequent Injuries Fund balance for a fiscal year, the balance shall be carried forward and credited to the subsequent year's Subsequent Injuries Fund Assessment.

(c) In the event of an unexpended surplus in the Labor Enforcement and Compliance Fund balance for a fiscal year, the balance shall be carried forward and credited to the subsequent year's Labor Enforcement and Compliance Fund Assessment.

(d) In the event of an unexpended surplus in the Occupational Safety and Health Fund balance for a fiscal year, the balance shall be carried forward and credited to the subsequent year's Occupational Safety and Health Assessment.

(e) In the event of an unexpended surplus in the Uninsured Employers Fund balance for a fiscal year, the balance shall be carried forward and credited to the subsequent year's Uninsured Employers Fund Assessment.

Note: Authority cited: Sections 54, 55 and 62.5, Labor Code. Reference: Section 62.5, Labor Code.

HISTORY

1. Renumbering of former section 15604 to section 15605 and new section 15604 filed 1-15-93 as an emergency; operative 1-15-93 (Register 93, No. 3). A Certificate of Compliance must be transmitted to OAL 5-17-93 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 1-15-93 order transmitted to OAL 5-10-93 and filed 6-16-93 (Register 93, No. 25).

3. Change without regulatory effect repealing section filed 12-15-99 pursuant to section 100, title 1, California Code of Regulations (Register 99, No. 51).

4. New section filed 1-14-2000 as an emergency; operative 1-14-2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-

15-2000 or emergency language will be repealed by operation of law on the following day.

5. Certificate of Compliance as to 1-14-2000 order transmitted to OAL 5-9-2000 and filed 6-15-2000 (Register 2000, No. 24).

6. Amendment filed 12-18-2003; operative 12-18-2003. Submitted to OAL for printing only (Register 2003, No. 51).

7. New subsection (c) and subsection relettering filed 11-12-2008; operative 11-12-2008. Submitted to OAL for printing only (Register 2008, No. 46).

8. New subsection (c) and subsection relettering filed 11-19-2009; operative 11-19-2009. Submitted to OAL for printing only (Register 2009, No. 47).

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Article 3. Collection of Assessments and/or Surcharges

New query

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§15605. Collection of the Revolving Fund Assessment and Fraud Surcharge from Self-Insured Employers.

(a) The Director designates the Manager of Self-Insurance Plans to collect the Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Labor Enforcement and Compliance Fund Assessment, Occupational Safety and Health Fund Assessment, Uninsured Employers Fund Assessment, and/or Fraud Surcharge from self-insured employers on the Director's behalf.

(b) No later than December 1 of each year, the Manager of Self-Insurance Plans shall bill each self-insured employer for the amount of the individual self-insured employer's Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Labor Enforcement and Compliance Fund Assessment, Occupational Safety and Health Fund Assessment, Uninsured Employers Fund Assessment, and/or Fraud Surcharge. The billing shall identify each assessment and/or surcharge separately and shall include the calculations utilized to determine each assessment factor. Each individual assessment and/or surcharge shall be determined by multiplying the self-insured employer assessment factor by the total amount of worker's compensation indemnity paid and reported by each self-insured employer on its Self-Insurer's Annual Report during the base year, as determined by the Office of Self-Insurance Plans. The Self-Insurer's Annual Report shall include all indemnity payments as defined in section 15600 (e).

(c) The amount of any assessment and/or surcharge shall be paid to the Office of Self-Insurance Plans within 30 days of the billing. Upon the request of any Joint Powers Authority, the Manager may agree to bill the Joint Powers Authority directly for the total amount of each assessment and/or surcharge owed by its public agency members.

(d) In the event the Manager collects funds in excess of the total self-insured employer assessment in the (1) Revolving Fund Assessment; (2) Subsequent Injuries Fund Assessment; (3) Labor Enforcement and Compliance Fund Assessment, (4) Occupational Safety and Health Fund Assessment; (5) Uninsured Employers Fund Assessment; and/or (6) Fraud Surcharge, such excess funds shall be paid over to the Director to be held in a trust account and credited to the next year's respective assessments and/or surcharge on self-insured employers.

(e) Should the Manager determine that any self-insured employer has understated or overstated its total payroll or indemnity paid on the self-insured employer's annual report, the Manager may issue a corrected billing.

(f) If an employer has paid the assessments and/or surcharge as an insured employer, and during the year of such assessments and/or surcharge is granted a certificate of consent to self-insure, the newly self-insured employer is not required to pay an additional assessments and/or surcharge as a self-insured employer for the current assessments and/or surcharge year. Such an employer shall submit to the Manager a copy of the assessments and/or surcharge

billing paid as insured employer in lieu of payment as a self-insured employer.

(g) A self-insured employer that does not have a self-insurers' annual report on file with the Office of Self-Insurance Plans which covers the base year of the assessments and/or surcharge, and that did not pay the assessments and/or surcharge for the base year as an insured employer, shall pay the assessments and/or surcharge through the Office of Self-Insurance Plans.

(1) To enable the Manager to determine such self-insured employer's liability for the assessments and/or surcharge, each such self-insured employer shall file a report prescribed by the Manager, setting forth such self-insured employer's total annual payroll for the base year, and the total workers' compensation premium paid for each calendar quarter of the preceding year.

(2) The Manager shall bill the self-insured employer by applying the self-insured employer assessment factors to the last annual premium paid by the self-insured employer until the self-insured employer's experience as a self-insured employer exceeds two complete calendar years for private self-insured employers or two complete fiscal years for public self-insured employers.

(h) A self-insured employer that ceases to be self-insured and ceases to operate as a functioning employer with no legal requirement to secure the payment of compensation, but continues to have open workers' compensation claims arising from the period of self-insurance, shall continue to be liable for assessments and/or surcharge for a period of 3 calendar years following the termination, revocation, or surrender of the employer's certificate of consent to self-insure. The Manager shall bill the former self-insured employer in accordance with this Section.

Note: Authority cited: Sections 54, 55 and 62.5, Labor Code; and Section 1872.83, Insurance Code. Reference: Sections 62.5 and 62.6, Labor Code; and Section 1872.83, Insurance Code.

HISTORY

1. New section filed 4-18-90 as an emergency; operative 4-18-90 (Register 90, No. 18). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 8-16-90.

2. Certificate of Compliance as to 4-18-90 order including amendment to subsections (b), (c) and (e) and adding subsection (f), (g) and (h) transmitted to OAL 8-14-90 and filed 9-13-90 (Register 90, No. 43).

3. Renumbering of former section 15605 to section 15606 and renumbering of former section 15604 to section 15605 and amendment of section heading, section, and Note filed 1-15-93 as an emergency; operative 1-15-93 (Register 93, No. 3). A Certificate of Compliance must be transmitted to OAL 5-17-93 or emergency language will be repealed by operation of law on the following day.

4. Editorial correction restoring inadvertently omitted article heading (Register 93, No. 25).

5. Certificate of Compliance as to 1-15-93 order including amendment of subsection (F) transmitted to OAL 5-10-93 and filed 6-16-93 (Register 93, No. 25).

6. Amendment of article heading, section heading, subsections (a), (e), (f) and (h) and Note filed 9-6-94 as an emergency; operative 9-6-94 (Register 94,

No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 9-6-94 order including amendment of subsections (a)-(c) transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

8. Amendment of subsection (f) filed 11-14-95 as an emergency; operative 12-1-95 (Register 95, No. 46). A Certificate of Compliance must be transmitted to OAL by 3-30-96 or emergency language will be repealed by operation of law on the following day.

9. Certificate of Compliance as to 11-14-95 order transmitted to OAL 3-29-96 and filed 5-8-96 (Register 96, No. 19).

10. Change without regulatory effect amending section heading, section and Note filed 12-15-99 pursuant to
section 100, title 1, California Code ofRegulations (Register 99, No. 51).

11. Amendment of section heading, section and Note filed 1-14-2000 as an emergency; operative 1-14-2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-15-2000 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as to 1-14-2000 order transmitted to OAL 5-9-2000 and filed 6-15-2000 (Register 2000, No. 24).

13. Amendment of section heading and section filed 12-18-2003; operative 12-18-2003. Submitted to OAL for printing only (Register 2003, No. 51).

14. Amendment of section heading and subsections (a), (b) and (d) filed 11-12-2008; operative 11-12-2008. Submitted to OAL for printing only (Register 2008, No. 46).

15. Amendment of section heading and subsections (a), (b) and (d) filed 11-19-2009; operative 11-19-2009. Submitted to OAL for printing only (Register 2009, No. 47).

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Article 3. Collection of Assessments and/or Surcharges

New query

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§15605.5. Collection of Targeted Inspection Assessment from Self-Insured Employers. (Repealed)

NOTE: Authority cited: Sections 54, 55 and 62.7, Labor Code. Reference: Section 62.7, Labor Code.

HISTORY

1. New section filed 9-6-94 as an emergency; operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 9-6-94 order including amendment of section transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

3. Repealer filed 11-14-95 as an emergency; operative 12-1-95 (Register 95, No. 46). A Certificate of Compliance must be transmitted to OAL by 3-30-96 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 11-14-95 order transmitted to OAL 3-29-96 and filed 5-8-96 (Register 96, No. 19).

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Article 3. Collection of Assessments and/or Surcharges

New query

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§15606. Collection of Advances Against Insured Employers.

(a) Not later than December 1 of each year, the Director shall notify each workers' compensation insurer, of the amounts due from the insurer on behalf of its policyholders for, respectively, the Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Uninsured Employers Fund Assessment, Labor Enforcement and Compliance Fund Assessment, Occupational Safety and Health Fund Assessment, and the Fraud Surcharge levied pursuant to the authority of Labor Code Sections 62.5 and 62.6 and these regulations. The notice shall include a bill that sets forth separately the total amounts of the assessments and the surcharge.

(b) The Insurer advances against the Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Labor Enforcement and Compliance Fund Assessment, Occupational Safety and Health Fund Assessment, Uninsured Employers Fund Assessment, and Fraud Surcharge amounts shall be calculated by multiplying the insurer's California direct written workers' compensation premium as reported in the most recent year's financial statement on file with the Insurance Commissioner, multiplied by the ratio of the expected total current year premium to the total direct written workers' compensation premium of all insurers as reported in the latest year's annual financial statements on file with the Insurance Commissioner by the respective factors determined pursuant to subsection (a) of Section 15603 of these regulations.

(c) Where the amount of the assessments or surcharge owed is less than $5.00 the Director may elect not to bill the insurer therefor.

(d) Each insurer shall pay to the Director one half of the amounts billed under subsection (a) on behalf of its insured employers on or before the following January 1. Each insurer shall pay the balance of the assessments and surcharge to the Director on the following April 1.

(e) Upon agreement of the affected insurers, the Director may elect to consolidate in one billing the assessments and surcharge of all insured employers that are insured by insurers under the same management, direction and control.

(f) In the event the Director collects advances from insurers in excess of the total assessments and surcharge due from insured employers in the (1) Revolving Fund Assessment; (2) Subsequent Injuries Fund Assessment; (3) Labor Enforcement and Compliance Fund Assessment; (4) Occupational Safety and Health Fund Assessment; (5) Uninsured Employers Fund Assessment; and/or (6) Fraud Surcharge, the excess funds shall be held by the Director in a trust account and credited to the subsequent year's total respective assessments and surcharge on insured employers.

(g) Commencing with the assessment payment due April 1, 1993, the insurer shall submit a summary report on a form provided by the Director, which includes the following information: (1) the total amount of assessments and surcharges billed insured employers by the insurer; (2) the respective factors used by the insurer in assessing and surcharging insured employers.

(h) The summary report due April 1, 1993 shall include the information specified in this subsection for all workers' compensation insurance policies with an inception date between August 1, 1990 and December 31, 1991. Commencing April 1, 1994, the summary report shall include the information specified in this subsection for all workers' compensation insurance policies with an inception date in the next preceding calendar years.

Note: Authority cited: Sections 54, 55 and 62.5, Labor Code; and Section 1872.83, Insurance Code. Reference: Sections 62.5 and 62.6, Labor Code; and Section 1872.83, Insurance Code.

HISTORY

1. New section filed 4-18-90 as an emergency; operative 4-18-90 (Register 90, No. 18). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 8-16-90.

2. Certificate of Compliance as to 4-18-90 order including amendment to subsection (a), (d) and (e) transmitted to OAL 8-14-90 and filed 9-13-90 (Register 90, No. 43).

3. Renumbering of former section 15606 to 15607 and renumbering of former section 15605 to section 15606 and amendment of section and Note filed 1-15-93 as an emergency; operative 1-15-93 (Register 93, No. 3). A Certificate of Compliance must be transmitted to OAL 5-17-93 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 1-15-93 order including amendment of subsection (a) and repealer of subsection (e)(3) transmitted to OAL 5-10-93 and filed 6-16-93 (Register 93, No. 25).

5. Amendment of subsections (a)-(d) and Note filed 9-6-94 as an emergency; operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9-6-94 order including amendment of section heading, repealer of subsections (a)-(e) and new subsections (a)-(i) transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

7. Amendment of subsections (a)-(b), repealer of subsection (c), subsection relettering and amendment of Note filed 11-14-95 as an emergency; operative 12-1-95 (Register 95, No. 46). A Certificate of Compliance must be transmitted to OAL by 3-30-96 or emergency language will be repealed by operation of law on the following day.

8. Certificate of Compliance as to 11-14-95 order transmitted to OAL 3-29-96 and filed 5-8-96 (Register 96, No. 19).

9. Change without regulatory effect amending section and Note filed 12-15-99 pursuant to section 100, title 1, California Code of Regulations (Register

99, No. 51).

10. Amendment of section and Note filed 1-14-2000 as an emergency; operative 1-14-2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-15-2000 or emergency language will be repealed by operation of law on the following day.

11. Certificate of Compliance as to 1-14-2000 order transmitted to OAL 5-9-2000 and filed 6-15-2000 (Register 2000, No. 24).

12. Amendment of subsections (a), (b) and (f) filed 12-18-2003; operative 12-18-2003. Submitted to OAL for printing only (Register 2003, No. 51).

13. Amendment of section heading and subsections (a), (b) and (f) filed 11-12-2008; operative 11-12-2008. Submitted to OAL for printing only (Register 2008, No. 46).

14. Amendment of subsections (a), (b) and (f) filed 11-19-2009; operative 11-19-2009. Submitted to OAL for printing only (Register 2009, No. 47).

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Article 3. Collection of Assessments and/or Surcharges

New query

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§15607. Collection of Revolving Fund Assessment and Fraud Surcharge from Insured Employers.

(a) Every insurer shall collect the Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Labor Enforcement and Compliance Fund Assessment, Occupational Safety and Health Fund Assessment, Uninsured Employers Fund Assessment, and Fraud Surcharge required by this article and Labor Code Sections 62.5 and 62.6, respectively, from each employer insured by it by applying a separate charge to all workers' compensation insurance policies issued by such insurer with an inception date in the year beginning January 1 after the determinations required by Sections 15601 and 15601.5 of these regulations. The amount of the assessment and surcharge shall be determined by multiplying the insured employer's estimated annual assessable premium by the assessment factors determined by the Director pursuant to subsection (a) of section 15603. The assessment factors in effect on the inception date of the policy shall be used to calculate the separate charges relative to that policy, including any additional or return premium.

(b) The respective amounts of the Revolving Fund Assessment, Subsequent Injuries Fund Assessment, Labor Enforcement and Compliance Fund Assessment, Occupational Safety and Health Fund Assessment, Uninsured Employers Fund Assessment, and Fraud surcharge shall each be rounded to the nearest whole dollar, and be respectively shown in the policy as "Workers' Compensation Administration Revolving Fund Assessment (amount)," "Subsequent Injuries Benefits Trust Fund Assessment (amount)," "Labor Enforcement and Compliance Fund Assessment (amount)," "Occupational Safety and Health Fund Assessment (amount)," "Uninsured Employers Benefits Trust Fund Assessment (amount)," and "State Fraud Surcharge (amount)".

(c) Commencing with policies effective on and after January 1, 1993, the insured employer's separate charges calculated under subsection (a) above shall be collected in full with the initial payment of assessable premium. If additional premium becomes due under the policy, the final amount of the separate charges shall be adjusted with the final premium bill for the policy. In the case of a retrospective rated policy, the respective assessment and/or surcharge should be applied to the policy premium at issuance, with recalculation at audit, and application of the factors to any retrospective adjustment premium.

(d) Notwithstanding the requirements of this Section, an insurer may elect not to bill an insured employer for the assessments and surcharge for the additional premium due under the policy if the amount of the additional assessments or surcharge does not exceed $10.00. In the event a return premium is due the employer, the insurer shall return a pro rata share of assessments and surcharge previously paid by the employer unless the assessments and surcharge overpayment does not exceed $10.00.
(e) A self-insurer whose certificate has been revoked during the base year or during the calendar year prior to the

current assessments and/or surcharge billing by the Manager shall be exempt from payment of the assessments and/or surcharge as a self-insurer.

(f) If an employer has paid the assessments and/or surcharge as a self-insured employer, and during the year of such assessment and/or surcharge obtains a policy of workers' compensation insurance, the newly insured employer is not required to make assessments and/or surcharge payments as an insured employer for that year's assessments and/or surcharge. Such an employer shall submit to the insurer a copy of the assessments and/or surcharge billing paid as a self-insured employer, in lieu of payment as an insured employer.

Note: Authority cited: Sections 54, 55 and 62.5, Labor Code; and Section 1872.83, Insurance Code. Reference: Sections 62.5 and 62.6, Labor Code; and Section 1872.83, Insurance Code.

HISTORY

1. New section filed 4-18-90 as an emergency; operative 4-18-90 (Register 90, No. 18). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 8-16-90.

2. Certificate of Compliance as to 4-18-90 order including amendment to subsections (a), (b), and (c) and adding subsection (d) transmitted to OAL 8 - 14-90 and filed 9-13-90 (Register 90, No. 43).

3. Renumbering of former section 15607 to 15608 and renumbering of former section 15606 to section 15607 and amendment of section heading, section, and Note filed 1-15-93 as an emergency; operative 1-15-93 (Register 93, No. 3). A Certificate of Compliance must be transmitted to OAL 5-17-93 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 1-15-93 order including amendment of subsections (b) and (d) transmitted to OAL 5-10-93 and filed 6-16-93 (Register 93, No. 25).

5. Amendment of subsections (a), (b), (d) and Note filed 9-6-94 as an emergency; operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9-6-94 order including amendment of section heading, subsections (a), (b), and (d), and Note transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

7. Amendment of subsections (a) and (d), and new subsections (e)-(f) filed 11-14-95 as an emergency; operative 12-1-95 (Register 95, No. 46). A Certificate of Compliance must be transmitted to OAL by 3-30-96 or emergency language will be repealed by operation of law on the following day.

8. Certificate of Compliance as to 11-14-95 order transmitted to OAL 3-29-96 and filed 5-8-96 (Register 96, No. 19).

9. Amendment of subsections (a), (c) and (d) filed 11-10-97; operative 11-10-97 pursuant to Government Code section 11343.4(d) (Register 97, No. 46).

10. Change without regulatory effect amending section heading, section and Note

filed 12-15-99 pursuant to
section 100, title 1, California Code ofRegulations (Register 99, No. 51).

11. Amendment of section heading, section and Note filed 1-14-2000 as an emergency; operative 1-14-2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-15-2000 or emergency language will be repealed by operation of law on the following day.

12. Certificate of Compliance as to 1-14-2000 order transmitted to OAL 5-9-2000 and filed 6-15-2000 (Register 2000, No. 24).

13. Amendment of section heading and section filed 12-18-2003; operative 12-18-2003. Submitted to OAL for printing only (Register 2003, No. 51).

14. Amendment of section heading and subsections (a) and (b) filed 11-12-2008; operative 11-12-2008. Submitted to OAL for printing only (Register 2008, No. 46).

15. Amendment of section heading and subsections (a) and (b) filed 11-19-2009; operative 11-19-2009. Submitted to OAL for printing only (Register 2009, No. 47).

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Article 3. Collection of Assessments and/or Surcharges

New query

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§15607.5. Collection of Targeted Inspection Assessment from Insured Employers. (Repealed)

NOTE: Authority cited: Sections 54, 55 and 62.7, Labor Code. Reference: Section 62.7, Labor Code.

HISTORY

1. New section filed 9-6-94 as an emergency; operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 9-6-94 order including designation of subsections (a)-(e), amendment of subsections (b) and (d), and new subsections (f)-(g) transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

3. Repealer filed 11-14-95 as an emergency; operative 12-1-95 (Register 95, No. 46). A Certificate of Compliance must be transmitted to OAL by 3-30-96 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 11-14-95 order transmitted to OAL 3-29-96 and filed 5-8-96 (Register 96, No. 19).

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Article 3. Collection of Assessments and/or Surcharges

New query

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§15608. Assessment and/or Surcharge Collection in Excess of Insured Employer Assessment Advance.

If the summary report required by subsections (g) and (h) of Section 15606 of these regulations shows that the insurer has collected assessments and surcharges from employers in excess of the advances paid to the Director for policies incepting in the calendar year covered by the summary report, the insurer shall pay the excess amount to the Director upon submission of the summary report. The Director shall hold any excess amounts in a trust account and either credit the respective amounts to any deficiency in the current assessments and surcharge, or, if there is no deficiency, to the subsequent year's respective assessments and/or surcharges on insured employers.

Note: Authority cited: Sections 54, 55 and 62.5, Labor Code; and Section 1872.83, Insurance Code. Reference: Sections 62.5 and 62.6, Labor Code; and Section 1872.83, Insurance Code.

HISTORY

1. New section filed 4-18-90 as an emergency; operative 4-18-90 (Register 90, No. 18). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 8-16-90.

2. Certificate of Compliance as to 4-18-90 order including amendment transmitted to OAL 8-14-90 and filed 9-13-90 (Register 90, No. 43).

3. Renumbering of former section 15608 to 15609 and renumbering of former section 15607 to section 15608 and amendment of section heading, section, and Note filed 1-15-93 as an emergency; operative 1-15-93 (Register 93, No. 3). A Certificate of Compliance must be transmitted to OAL 5-17-93 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 1-15-93 order transmitted to OAL 5-10-93 and filed 6-16-93 (Register 93, No. 25).

5. Amendment of Note filed 9-6-94 as an emergency; operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following

day.

6. Certificate of Compliance as to 9-6-94 order including amendment of section transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

7. Amendment of section and Note filed 11-14-95 as an emergency; operative 12-1-95 (Register 95, No. 46). A Certificate of Compliance must be transmitted to OAL by 3-30-96 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 11-14-95 order transmitted to OAL 3-29-96 and filed 5-8-96 (Register 96, No. 19).

9. Change without regulatory effect amending section heading, section and Note filed 12-15-99 pursuant to
section 100, title 1, California Code ofRegulations (Register 99, No. 51).

10. Amendment of section heading, section and Note filed 1-14-2000 as an emergency; operative 1-14-2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-15-2000 or emergency language will be repealed by operation of law on the following day.

11. Certificate of Compliance as to 1-14-2000 order transmitted to OAL 5-9-2000 and filed 6-15-2000 (Register 2000, No. 24).

12. Amendment filed 12-18-2003; operative 12-18-2003. Submitted to OAL for printing only (Register 2003, No. 51).


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Article 3. Collection of Assessments and/or Surcharges

New query

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§15609. Credit for Undercollection.

(a) When an insurer demonstrates to the Director, within one year of the final audit conducted for premium adjustments for the policies with inception dates in the year subject to assessment, that the total assessments and/or surcharges, respectively, collected from its insured employers is less than the respective assessment and surcharge amounts advanced by the insurer under Section 15606 for that assessment year, the Director shall credit the amount of the difference against the subsequent year's respective advances due from the insurer on behalf of its insured employers.

(b) No insurer shall receive any credit for any portion of an undercollection against advances paid by that insurer that is due to the insurer's failure to properly bill a policyholder for the appropriate assessments and/or surcharges applicable to the premium for that policyholder's policy.

NOTE

Authority cited: Sections 54, 55 and 62.5, Labor Code; and Section 1872.83, Insurance Code. Reference: Sections 62.5 and 62.6, Labor Code; and Section 1872.83, Insurance Code.

HISTORY

1. New section filed 4-18-90 as an emergency; operative 4-18-90 (Register 90, No. 18). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 8-16-90.

2. Certificate of Compliance as to 4-18-90 order including amendment transmitted to OAL 8-14-90 and filed 9-13-90 (Register 90, No. 43).

3. Repealer of former section 15609 and renumbering and amendment of former section 15608 to section 15609 filed 1-15-93 as an emergency; operative 1-15-93 (Register 93, No. 3). A Certificate of Compliance must be transmitted to OAL 5-17-93 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 1-15-93 order transmitted to OAL 5-10-93 and filed 6-16-93 (Register 93, No. 25).

5. Amendment of section and Note filed 9-6-94 as an emergency; operative 9-6-94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1-4-95 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9-6-94 order including amendment of section transmitted to OAL 12-30-94 and filed 2-15-95 (Register 95, No. 7).

7. Amendment filed 5-8-96; operative 5-8-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 19).

8. New subsection (a) designator and new subsection (b) filed 11-10-97; operative 11-10-97 pursuant to Government Code section 11343.4(d) (Register 97, No. 46).

9. Change without regulatory effect amending section and Note filed 12-15-99 pursuant to section 100, title 1, California Code of Regulations (Register 99, No. 51).

10. Amendment of section and Note filed 1-14-2000 as an emergency; operative 1-14-2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5-15-2000 or emergency language will be repealed by operation of law on the following day.

11. Certificate of Compliance as to 1-14-2000 order transmitted to OAL 5-9-2000 and filed 6-15-2000 (Register 2000, No. 24).

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Article 3. Collection of Assessments and/or Surcharges

New query

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§15610. Collections of 1995 Interim Targeted Inspection Assessment.

NOTE

Authority cited: Sections 54, 55 and 62.7, Labor Code; and Section 1872.83, Insurance Code. Reference: Section 62.5, Labor Code; and Section 1872.83, Insurance Code.

HISTORY

1. New section filed 4-18-90 as an emergency; operative 4-18-90 (Register 90, No. 18). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 8-16-90.

2. Certificate of Compliance as to 4-18-90 order transmitted to OAL 8-14-90 and filed 9-13-90 (Register 90, No. 43).

3. Repealer filed 1-15-93 as an emergency; operative 1-15-93 (Register 93, No. 3). A Certificate of Compliance must be transmitted to OAL 5-17-93 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 1-15-93 order transmitted to OAL 5-10-93 and filed 6-16-93 (Register 93, No. 25).

5. New section filed 2-15-95; operative 3-17-95 (Register 95, No. 7).

6. Repealer filed 12-18-2003; operative 12-18-2003. Submitted to OAL for printing only (Register 2003, No. 51).

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Article 3. Collection of Assessments and/or Surcharges

New query

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§15611. Collection of Interim Assessments

(a) Notwithstanding the provisions of this subchapter, if the Director determines that there are insufficient funds to support the Workers' Compensation Administration Revolving Fund, the Subsequent Injuries Fund, the Labor Enforcement and Compliance Fund, the Occupational Safety and Health Fund, or the Uninsured Employers Fund for fiscal year 2003-2004, or any fiscal year thereafter, the Director may collect a single interim assessment for these respective funds, in an amount determined by the Director, to provide sufficient funding for these funds.

(b) Any assessment collected under this Section shall not reduce the amount to be collected in the subsequent year's assessments, except as provided by Section 15608 of these regulations.

(c) Any assessment collected under this Section shall be included on the next annual report required under Section 15606(g) of these regulations.

Note: Authority cited: Sections 54, 55 and 62.5, Labor Code. Reference: Section 62.5, Labor Code.

HISTORY

1. New section filed 12-18-2003; operative 12-18-2003. Submitted to OAL for printing only (Register 2003, No. 51).

2. Amendment of subsection (a) filed 11-12-2008; operative 11-12-2008. Submitted to OAL for printing only (Register 2008, No. 46).

3. Amendment of subsection (a) filed 11-19-2009; operative 11-19-2009. Submitted to OAL for printing only (Register 2009, No. 47).

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Article 1. General

New query

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§15710. Definitions.

The following definitions are applicable to this group. Terms not defined here but used in the Labor Code shall have their meaning as so used. All references to the code or to code sections refer to the California Labor Code unless otherwise stated.

(a) Prima facie illegally uninsured. In addition to examples provided in the code, an employer against which there is any evidence from which, after considering any contradicting evidence except any testimony or statements by the employer or related persons, a reasonable person could conclude that the employer, as of the time of the injury, had not secured the payment of compensation as provided by code Section 3700.

(b) Prima facie a parent. A corporation against which there is any evidence from which, after considering any contradictory evidence except testimony or statements of shareholders, officers or beneficial owners of the parent or its subsidiary, a reasonable person could conclude that the corporation had been at the time of the injury or has been at any subsequent time the parent of a corporation which, as of the time of the injury, had not secured the payment of compensation as provided by code Section 3700.

(c) Prima facie a substantial shareholder. A person against which there is any evidence from which, after considering any contradictory evidence except testimony or statements of that person or of related persons or other shareholders, a reasonable person could conclude that the person had been at the time of the injury or has been at any subsequent time a substantial shareholder in a corporation or the parent of a corporation, which corporation, as of the time of the injury, had not secured the payment of compensation as provided by code Section 3700.

(d) Prima facie case. A case for which there is any evidence from which, after considering any contradictory evidence, a reasonable person could conclude that the case were established as likely to be true.

(e) Director. The Director of Industrial Relations or his designated agents or delegates.

(f) Illegally uninsured. The status of having employees, one of whom was injured arising out of and in the course of the employee's employment at a time when the employer had not secured the payment of compensation as required by code Section 3800.

(g) Appeals board. The California Workers Compensation Appeals Board.

NOTE: Authority cited: Sections 54, 55, 59, 3702.10, 3710 and 3715, Labor Code. Reference: Sections 3715, 3717.2, 3720, 3720.1 and 3721, Labor Code.

HISTORY

1. New section filed 6-19-89; operative 7-19-89 (Register 89, No. 27). For history of former Group 2.1 (Sections 15600-15670 and Sections 15700-15780, not consecutive), see Register 83, No. 31.

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Article 1. General

New query

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§15711. Delegation of Authority.

The director delegates authority to the Chief of the Claims Bureau of the Uninsured Employers Fund to make the determination under Labor Code Sections 3715(c), 3720(c), and 3720.1(a), to reconsider determinations made pursuant to code Sections 3715(c) and 3720.1(a), to file liens, to remove liens erroneously filed, to remove liens pursuant to code Section 3720(c), to collect funds on liens, refund funds erroneously collected, issue the notices pursuant to code Section 3715(d), and otherwise to administer the program relating to liens issued prior to the issuance of findings and awards of the appeals board, in appeals board cases involving illegally uninsured employers. The Chief of the Claims Bureau may, as he or she deems necessary, delegate all or any part of the authority granted herein to the area supervisors within the Claims Bureau.

NOTE: Authority cited: Sections 54, 55, 59, 3702.10, 3710 and 3715, Labor Code. Reference: Sections 3715, 3717.2, 3720, 3720.1 and 3721, Labor Code.

HISTORY

1. New section filed 6-19-89; operative 7-19-89 (Register 89, No. 27). For history of former Group 2.1 (Sections 15600-15670 and Sections 15700-15780, not consecutive), see Register 83, No. 31.

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Article 2. Determinations by Director

New query

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§15720. Determinations.

The director shall make all determinations under code Section 3715(c) of whether a person involved in a claim before the Appeals Board is prima facie illegally insured. The director may make determinations pursuant to code Section 3715(c) in any case in which the director, as administrator of the Uninsured Employers Fund, has been joined or otherwise made a party. In all cases where the employer or alleged employer is a corporation and where the director has not petitioned the appeals board to make a determination under code Section 3717.2 or, pending a determination in such cases, the director may make determinations pursuant to code Section 3720.1 of status of prima facie a parent or prima facie a substantial shareholder. The director shall record written reasons for his determinations. These reasons shall be included with the notice of determination.

NOTE: Authority cited: Sections 54, 55, 59, 3702.10, 3710 and 3715, Labor Code. Reference: Sections 3715, 3717.2, 3720, 3720.1 and 3721, Labor Code.

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Article 2. Determinations by Director

New query

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§15721. Negative Inferences.

If information or documentary proof has been requested by the director from the alleged uninsured employer, and the alleged uninsured employer has not supplied such information or documents, and if the information, documents or copies thereof can reasonably be assumed to be in the possession or control of the alleged uninsured employer, the director shall infer from the failure to comply with the request that the documents do not exist, or that the information or the contents of the documents establish that the alleged uninsured employer was illegally uninsured, or that there was substantial shareholder or parent status, whichever is applicable.

NOTE: Authority cited: Sections 54, 55, 59, 3702.10, 3710 and 3715, Labor Code. Reference: Sections 3715, 3717.2, 3720, 3720.1 and 3721, Labor Code.

HISTORY

1. New section filed 6-19-89; operative 7-19-89 (Register 89, No. 27). For history of former Group 2.1 (Sections 15600-15670, not consecutive), see Register 83, No. 31.

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Subchapter 2.1. Illegally Uninsured Employers. Determinations by the Director: Prima Facie Illegally Uninsured, Corporate Parent and Substantial Shareholder; Notice; Hearings; Appeals
Article 2. Determinations by Director

New query

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§15722. Reconsideration of Section 3715 (c) Determinations; Finality.

Upon receipt of written protest or application for reconsideration from an aggrieved person, of a determination that an employer was prima facie illegally uninsured, the Chief of the Claims Bureau, Uninsured Employers Fund, on the director's behalf, shall informally reconsider the determination. The aggrieved person shall furnish a statement of reasons why the determination was in error, and any evidence in support of the position of the aggrieved person. The Chief of the Claims Bureau may uphold, rescind, or alter the original determination. The decision after reconsideration shall be mailed to the aggrieved person and to other persons to whom the original notice was sent, within five working days after receipt of the protest or application for reconsideration. A request of the reconsideration under this section shall be a prerequisite to filing of a petition with the appeals board pursuant to code Section 3715(d). For purposes of the time within which the petition must be filed with appeals board, the determination shall not be considered to be final until after the decision after reconsideration is mailed.

NOTE: Authority cited: Sections 54, 55, 59, 3702.10, 3710 and 3715, Labor Code. Reference: Sections 3715, 3717.2, 3720, 3720.1 and 3721, Labor Code.

HISTORY

1. New section filed 6-19-89; operative 7-19-89 (Register 89, No. 27). For history of Group 2.1 (Sections 15600-15670 and Sections 15700-15780, not consecutive), see Register 83, No. 31.

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Article 2. Determinations by Director

New query

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§15723. Reconsideration of Section 3720.1(a) Determinations; Finality.

Upon receipt of written protest or application for reconsideration from an aggrieved person of a determination that a person was prima facie, a parent or a substantial shareholder, the Chief of the Claims Bureau, Uninsured Employers Fund, on the director's behalf, shall informally reconsider the determination. The aggrieved person shall furnish a statement of reasons why the determination was in error, and any evidence in support of the position of the aggrieved person. The Chief of the Claims Bureau may uphold, rescind, or alter the original determination. The decision after reconsideration shall be mailed to the aggrieved person, and to other persons to whom the original notice was sent, within five working days after receipt of the protest or application for reconsideration. A request for reconsideration under this section shall be a prerequisite to a filing of a request for a hearing pursuant to code Section 3720.1.

(b). A request for hearing filed prior to a protest or application for reconsideration shall be deemed a request for reconsideration. The time for filing a request shall not begin to run until the notice of decision after reconsideration is issued.

NOTE: Authority cited: Sections 54, 55, 59, 3702.10, 3710 and 3715, Labor Code. Reference: Sections 3715, 3717.2, 3720, 3720.1 and 3721, Labor Code.

HISTORY

1. New section filed 6-19-89; operative 7-19-89 (Register 89, No. 27). For history of former Group 2.1 (Sections 15600-15670, not consecutive), see Register 83, No. 31.

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Article 3. Hearings Under Code Section 3720.1

New query

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§15730. Administrative Hearing.

Upon the petition of an aggrieved person, if the petition is not treated as a request for informal reconsideration pursuant to Section 15723, the director shall hold a hearing to review prima facie substantial shareholder or parent status.

NOTE: Authority cited: Sections 54, 55, 59, 3702.10, 3710 and 3715, Labor Code. Reference: Sections 3715, 3717.2, 3720, 3720.1 and 3721, Labor Code.

HISTORY

1. New section filed 6-19-89; operative 7-19-89 (Register 89, No. 27). For history of former Group 2.1 (Sections 15600-15670, not consecutive), see Register 83, No. 31.

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New query

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§15731. Delegation of Authority.

The director delegates authority to the Chief Counsel of the Department of Industrial Relations to appoint hearing officers and to issue the notices for hearings being held pursuant to code section 3720.1(b). The hearing officer appointed shall not have been involved in the representation of the director before the appeals board in that particular case.

NOTE: Authority cited: Sections 54, 55, 59, 3702.10, 3710 and 3715, Labor Code. Reference: Sections 3715, 3717.2, 3720, 3720.1 and 3721, Labor Code.

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Article 3. Hearings Under Code Section 3720.1

New query

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§15732. Conduct of Hearing.

(a) Hearing Officer. The hearing officer shall have full authority as the director would to make all decisions necessary for the proper conduct of the hearing and for the making of a decision thereon. Not limiting the foregoing, the hearing officer may administer oaths, take testimony, admit or exclude evidence, schedule the hearing, continue or adjourn the hearing, require a statement of contentions, issue a subpoena and subpoena duces tecum for the attendance of a person and the production of testimony, books, or documents, and to decide when the case is submitted for decision.

(b) Admissible Evidence. The California Evidence Code and the common law rules of evidence shall not apply in the hearing, and the hearing officer may admit, consider, and rely upon evidence which would not be admissible if such rules of evidence governed.

(c) Testimony under Oath. All witnesses testifying before the hearing officer shall testify under oath, affirmation or penalty of perjury.

(d) Transcripts. The hearings shall be recorded by audio tape recording. A party desiring a transcript must pay for the transcription or provide and pay for a court reporter. In either case, a copy of the transcript must be provided to the director.

(e) Witness fees. Costs of subpoenaing witnesses are to be borne by the party requesting the subpoena.

(f) Documents. If a person seeking to establish that the person is not a parent or substantial shareholder does not produce corporate documents which relate the ownership of the applicable corporation, and there is evidence that the person was a shareholder or owner of a beneficial interest

in the corporation, the hearing officer may presume that the corporate documents not produced would contain evidence establishing the opposite of the contention asserted by the person not offering them.

NOTE: Authority cited: Sections 54, 55, 59, 3702.10, 3710 and 3715, Labor Code. Reference: Sections 3715, 3717.2, 3720, 3720.1 and 3721, Labor Code.

HISTORY

1. New section filed 6-19-89; operative 7-19-89 (Register 89, No. 27). For history of former Group 2.1 (Sections 15600-15670, not consecutive), see Register 83, No. 31.

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Chapter 8. Office of the Director
Subchapter 2.2 Uninsured Employers Fund and Subsequent Injuries Fund Benefits to Aliens
Article 1. Limitations on Benefits

New query

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§15740. Limitations on Uninsured Employers Fund and Subsequent Injuries Fund Benefits for Aliens.

(a) All eligibility requirements contained herein shall be applied without regard to the race, creed, color, gender, religion, or national origin of the individual applying for the public benefit.

(b) Pursuant to Section 411 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, (Pub. L. No. 104-193 (PRWORA)), (8 U.S.C. § 1621), and notwithstanding any other provision of this division, aliens who are not qualified aliens, nonimmigrant aliens under the Immigration and Nationality Act (INA) (8 U.S.C. § 1101 et seq.), or aliens paroled into the United States under Section 212(d) (5) of the INA (8 U.S.C. § 1182(d) (5)),for less than one year, are not eligible to receive benefits, including death benefits as the dependent of a deceased employee, from the UEF or SIF as set forth in Labor Code Sections 3716, 3716.2 and 4750-4755.

(c) A qualified alien is an alien who, at the time he or she applies for, receives, or attempts to receive benefits from the UEF or SIF, including death benefits as the dependent of a deceased employee, is, under Section 431 (b) of the PRWORA (8 U.S.C. § 1641 (b) and (c)), any of the following:

(1) An alien lawfully admitted for permanent residence under the INA (8 U.S.C. § 1101 et seq.).

(2) An alien who is granted asylum under Section 208 of the INA (8 U.S.C. § 1158).

(3) A refugee who is admitted to the United States under Section 207 of the INA (8 U.S.C. § 1157).

(4) An alien who is paroled into the United States under Section 212 (d) (5) of the INA (8 U.S.C. § 1182 (d) (5)) for a period of at least one year. (5) An alien whose deportation is being withheld under Section 243 (h) of the INA (8 U.S.C. § 11253 (h)) (as in effect immediately before the effective date of Section 307 of division C of Public Law 104-208) or Section 241(b)(2) of such Act (8 U. S. C. § 1251(b) (3)) (as amended by Section 305(a) of division C of Public Law 104-208).

(6) An alien who is granted conditional entry pursuant to Section 203 (a) (7) of the INA as in effect prior to April 1, 1980 (8 U. S. C. § 1153 (a) (7)) (See editorial note under 8 U.S.C. § 1101, "Effective Date of 1980 Amendment").

(7) An alien who is a Cuban or Haitian entrant (as defined in Section 501 (e) of the Refugee Education Assistance Act of 1980 (8 U. S. C. § 1522 note)).

(8) An alien who, under Section 431 (c) (1) of the PRWORA (8 U.S.C. § 1641 (c) (1), meets all of the conditions of subparagraphs (A), (B), (C), and (D) below:

(A) The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a

member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent of the alien consented to, or acquiesced in, such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered acts of violence.

(B) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the UEF or SIF. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

(i) The benefits are needed to enable the alien to become self-sufficient following separation from the abuser.

(ii) The benefits are needed to enable the alien to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien from the abuser.

(iii) The benefits are needed due to a loss of financial support resulting from the alien's separation from the abuser.

(iv) The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien to lose his or her job or to earn less or to require the alien to leave his or her job for safety reasons.

(v) The benefits are needed because the alien requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

(vi) The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into a day care for fear of being found by the abuser).

(vii) The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

(viii) The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien and/or to care for any resulting children.

(ix) Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien had when living with the abuser.

(C) The alien has been approved or has a petition pending which sets forth a prima facie case for:

(i) status as a spouse or child of a United States citizen pursuant to clause (ii), (iii), or (iv) of Section 204 (a) (1) (A) of the INA (8 U.S.C. § 1154 (a) (1) (A) (ii), (iii) or (iv)),

(ii) classification pursuant to clause (ii) or (iii) of Section 204 (a) (1) (B) of the INA (8 U.S.C. § 1254 (a) (1) (B) (ii) or (iii)),

(iii) cancellation of removal under 8 U. S. C. § 1229b as in effect prior to April 1, 1997,

(iv) status as a spouse or child of a United States citizen pursuant to clause (i) of Section 204 (a) (1) (A) of the INA (8 U.S.C. § 1154 (a) (1) (A)) or classification pursuant to clause (i) of Section 204 (a) (1) (B) of the INA (8 U.S.C. § 1154 (a) (1) (B)(i)).

(v) cancellation of removal pursuant to Section 240A (b) (2) of the INA (8 U. S. C. § 1229b (b) (2)).

(D) For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(9) An alien who meets all of the conditions of subparagraphs (A), (B), (C), (D) and (E) below:

(A) The alien has a child who has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent consented or acquiesced to such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered acts of violence.

(B) The alien did not actively participate in such battery or cruelty.

(C) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the UEF or SIF. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

(i) The benefits are needed to enable the alien's child to become self-sufficient following separation from the abuser.

(ii) The benefits are needed to enable the alien's child to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien's child from the abuser.

(iii) The benefits are needed due to a loss of financial support resulting from the alien's child's separation from the abuser.

(iv) The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien's child to lose his or her job or to earn less or to require the alien's child to leave his or her job for safety reasons.

(v) The benefits are needed because the alien's child requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

(vi) The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien's child's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into a day care for fear of being found by the abuser).

(vii) The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

(viii) The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien's child and/or to care for any resulting children.

(ix) Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien's child had when living with the abuser.

(D) The alien meets the requirements of subsection (c) (8) (C) above.

(E) For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(10) An alien child who meets all of the conditions of subparagraphs (A), (B), and (C) below:

(A) The alien child resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the

parent and the spouse consented or acquiesced to such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered acts of violence.

(B) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the UEF or SIF. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

(i) The benefits are needed to enable the alien child's parent to become self-sufficient following separation from the abuser.

(ii) The benefits are needed to enable the alien child's parent to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien child's parent from the abuser.

(iii) The benefits are needed due to a loss of financial support resulting from the alien child's parent's separation from the abuser.

(iv) The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien child's parent to lose his or her job or to earn less or to require the alien child's parent to leave his or her job for safety reasons.

(v) The benefits are needed because the alien child's parent requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

(vi) The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien child's parent's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into a day care for fear of being found by the abuser).

(vii) The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

(viii) The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien child's parent and/or to care for any resulting children.

(ix) Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien child's parent had when living with the abuser.

(C) The alien child meets the requirements of subsection (c)(8)(C) above.

(d) For purposes of this section, "nonimmigrant" is defined the same as in Section 101 (a) (15) of the INA (8 U.S.C. § 1101 (a) (15)).

(e) For purposes of establishing eligibility for Uninsured Employers Fund (UEF) and Subsequent Injuries Fund (SIF) benefits, all of the following must be met:

(1) The applicant must declare himself or herself to be a citizen of the United States or a qualified alien under subsection (c), a nonimmigrant alien under subsection (d), or an alien paroled into the United States for less than one year under Section 212 (d) (5) of the INA (8 U.S.C. § 1182 (d) (5)). The applicant shall declare that status through use of the "Statement of Citizenship, Alienage, and Immigration Status for State Public Benefits," Form UEF-1.

(2) The applicant must present documents of a type acceptable to the Immigration and Naturalization Services (INS) which serve as reasonable evidence of the applicant's declared status.

(3) The applicant must complete and sign Form UEF-1.

(4) Where authorized by the INS, the documentation presented by an alien as reasonable evidence of the alien's declared immigration status must be submitted to the INS for verification through the Systematic Alien Verification for Entitlements (SAVE) system procedures as follows:

(A) Unless the primary SAVE system is unavailable for use, the primary SAVE system verification must be used to access the biographical/immigration status computer record contained in the Alien Status Verification Index maintained by the INS. Subject to subparagraph (B), this procedure must be used to verify the status of all aliens who claim to be qualified aliens and who present an INS-issued document that contains an alien registration or alien admission number.

(B) In any of the following cases, the secondary SAVE system verification procedure must be used to forward copies of original INS documents evidencing an alien's status as a qualified alien, as a nonimmigrant alien under the INA, or as an alien paroled into the United States under Section 212 (d) (5) of the INA (8 U.S.C. § 1182 (d) (5)), for less than one year:

(i) The primary SAVE system is unavailable for verification.

(ii) A primary check of the Alien Status Verification Index instructs the Uninsured Employers Fund or Subsequent Injuries Fund to "institute secondary verification."

(iii) The document presented indicates immigration status but does not include an alien registration or alien admission number.

(iv) The Alien Status Verification Index record includes the alien registration or admission number on the document presented by the alien but does not match other information contained in the document.

(v) The document is suspected to be counterfeit or to have been altered.

(vi) The document includes an alien registration number in the A60 000 000 (not yet issued) or A80 000 000 (illegal border crossing) series.

(vii) The document is a fee receipt from INS for replacement of a lost, stolen, or unreadable INS document.

(viii) The document is one of the following: an INS Form I-181b notification letter issued in connection with an INS Form I-181 Memorandum of Creation of Record of Permanent Residence, an Arrival-Departure Record (INS Form I-94) or a foreign passport stamped "PROCESSED FOR I-551, TEMPORARY EVIDENCE OF LAWFUL PERMANENT RESIDENCE" that INS issued more than one year before the date of application for benefits from the UEF or SIF.

(5) Where verification through the SAVE system is not available, if the documents presented do not on their face reasonably appear to be genuine or to relate to the individual presenting them, the government entity that originally issued the document should be contacted for verification. With regard to naturalized citizens and derivative citizens presenting certificates of citizenship and aliens, the INS is the appropriate government entity to contact for verification. The UEF or SIF should request verification by the INS by filing INS Form G-845 with copies of the pertinent documents provided by the applicant with the local INS office. If the applicant has lost his or her original documents, or presents expired documents or is unable to present any documentation evidencing his or her immigration status, the applicant should be referred to the local INS office to obtain documentation.

(6) If the INS advises that the applicant has citizenship status or immigration status which makes him or her a qualified alien under the PRWORA, the INS verification should be accepted. If the INS advises that it cannot verify that the applicant has citizenship status or an immigration status that makes him or her a qualified alien, benefits shall be denied and the applicant notified of his or her rights to appeal the denial of benefits.

(7) Provided that the alien has completed and signed Form UEF-1 under penalty of perjury, eligibility for UEF or SIF benefits shall not be delayed, denied, reduced or terminated while the status of the alien is verified.

(f) Pursuant to Section 432 (d) of the PRWORA (8 U.S.C. § 1642 (d)), the UEF or SIF shall assure that a nonprofit charitable organization that provides federal, state, or local public benefits shall not be required to determine, verify, or otherwise require proof of eligibility of any applicant or beneficiary with respect to his or her immigration status or alienage.

(g) Pursuant to Section 434 of the PRWORA (8 U.S.C. § 1644), where the UEF or SIF reasonably believes that an alien is unlawfully in the State based on the failure of the alien to provide reasonable evidence of the alien's declared status, after an opportunity to do so, said alien shall be reported to the Immigration and Naturalization Service. (h) Nothing in this section shall be construed to withdraw eligibility for medical treatment required for an emergency medical condition under Section 411(b) of the PRWORA (8 U.S. § 1621(b)(1)). (i) Any applicant who is denied benefits, or whose benefits are terminated, pursuant to subsections (b) and (e), may file a Request for Administrative Review of benefit determination with the UEF Manager within 20 days of service of the notice of denial or termination of benefits from the UEF or SIF. The Request for Administrative Review shall be verified under penalty of perjury with proof of service on all parties, and shall provide a statement of reasons, as well as any relevant evidence, explaining why the determination of the UEF or SIF was in error.

(j) Upon receipt of the Request for Administrative Review, the UEF Manager shall informally reconsider the determination and shall issue a decision granting or denying the request within 45 days. A Request for Administrative Review as provided in subsection (i) shall be a prerequisite to the filing of a petition before the Workers' Compensation Appeals Board pursuant to subsection (k).

(k) Any applicant aggrieved by a decision of the UEF Manager on a Request for Administrative Review of benefit determination may file, within 20 days of service of the decision, a petition for relief before the Workers' Compensation Appeals Board. The petition shall be filed at the appeals board office that is designated for applications for adjudication of claim pursuant to Labor Code Section 5501.5., and shall be assigned to a workers' compensation judge for hearing and determination of the issues raised. A party aggrieved by the determination of the workers' compensation judge may seek relief from the determination in the same manner as specified for petitions for reconsideration pursuant to Labor Code Section 5900.

NOTE: Authority cited: Sections 54, 55, 59, 3702.10, 3716, 3716.1, 3716.2, 4751, Labor Code. Reference: Sections 1621, 1641 and 1642, Title 8, United States Code, Sections 3716, 3716.1, 3716.2, 4750-4755, 5501.5, Labor Code.

§15741 Statement of Citizenship, Alienage, and Immigration Status For State Public Benefits, Form UEF-1.

NOTE: Authority cited: Sections 54, 55, 59, 3702.10., 3716, 3716.1, 3716.2, 4751, Labor Code. Reference: Sections 1621, 1641 and 1642, Title 8, United States Code, Sections 3716, 3716.1, 3716.2, 4750-4755, Labor Code.

HISTORY

1. New section filed 11/27/98; Effective 11/27/98

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Article 1. Limitations on Benefits

New query

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§15741. Limitations on Uninsured Employers Fund and Subsequent Injuries Fund Benefits for Aliens. DWC Form UEF-1

Statement of Citizenship, Alienage, and Immigration Status for State Public Benefits Form UEF-1.

HISTORY

1. New section filed 11/27/98; Effective 11/27/98

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Division 1. Department of Industrial Relations
Chapter 8. Office of the Director

Subchapter 2.2. Uninsured Employers Fund and Subsequent Injuries Fund Benefits to Aliens

New query

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