California Workers' Compensation Handbook

Stanford D. Herlick

Twenty-Fifth Edition
2006

California

Workers' Compensation Handbook

A Practical Guide to the Workers' Compensation Law of California

Twenty-Fifth Edition
2006

By Stanford D. Herlick
Formerly Deputy Commissioner
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Preface

The value of a textbook on the California workers' compensation program depends in great measure on the qualifications of the author. The author of this Handbook is uniquely qualified as an expert on this subject. His experience as an advocate in this field includes representation of employers and insurers, as a Deputy Attorney General to the Subsequent Injuries Fund and the State Employees' Retirement System, as a County Counsel representing the county concerning lien claims for welfare and hospital charges, and as an advisor to a county retirement system for claims for disability retirement. His work has included cases on appeal to the W.C.A.B. for reconsideration and cases on review by California appellate courts and Supreme Court. He has also served as a referee-in-charge of a branch office of the Industrial Accident Commission and as a Deputy Commissioner reviewing appealed referee decisions.

The author has taught courses and conducted seminars on this subject for decades. His students have included representatives of the professions, as well as business, labor and governmental entities. In 1962, in connection with his courses, he developed a textbook of general application called the "Comp Primer" which is the forerunner of the present Handbook. The Handbook is a practical guide as well as a source of information respecting the meaning and interpretation of the California Workers' Compensation Law. It is designed for ease of reading and comprehension, rapid ascertainment of code sections, regulations and interpretative decisions, as well as providing assistance in the resolution of specific problems. It is kept current through annual revised editions which reflect statutory, regulatory, and decisional changes in the law.

The Publisher

Introduction

The Handbook

The California workers' compensation law has far-reaching effects. When employees suffer industrial injuries, not only is their welfare and that of their families involved, but also the interests of other individuals or groups. These include employers; employees; unions; insurers; brokers; agents; underwriters; physicians; lawyers; industrial relations staffs; and various benefits, hospital, or medical plans.

Problems related by students and others in these fields of activity influenced this attempt to provide a text that could serve as a practical guide to the interested layperson and professional as well. Our approach here is to present the scope and operation of this law in a single-volume handbook. There are many state agencies with rule-making authority involved in the various aspects of the law including the Division of Workers' Compensation, the Administrative Director, Workers' Compensation Appeals Board, Director of the Department of Industrial Relations, Insurance Commissioner and Workers' Compensation Insurance Rating Bureau. The Handbook provides information concerning the regulations and policies of these agencies that may not be readily available from other sources. References to legislative enactments and rules are placed in the margin for easier reading of the text; pertinent court and Board decisions are referenced on a selective basis.

The marginal references are to sections of the California Labor Code, Rules of the Administrative Director and Workers' Compensation Appeals Board, as well as sections of other California Codes covering special situations. These abbreviations will identify the codes and the rules:

B&P	—	Business & Professions Code
CC	—	Civil Code
CCP	—	Code of Civil Procedure
EC	—	Education Code
EvC	—	Evidence Code
F&Ag	—	Food and Agriculture Code
GC	—	Government Code
H&S	—	Health and Safety Code
IC	—	Insurance Code
LC	—	Labor Code
M&V	—	Military and Veterans Code
PC	—	Penal Code
PUC	—	Public Utilities Code

R	—	Rules of the Workers' Compensation Appeals Board, Administrative Director, and Director of Industrial Relations (sections of the California Code of Regulations)
R&T	—	Revenue and Taxation Code
UIC	—	Unemployment Insurance Code
W&I	—	Welfare and Institutions Code

Historical Background

While the belief that an employer should provide employees with some measure of protection from the effects of work injuries is not new, it has not been extensively held until modern times. During certain periods of recorded history, civilizations have established such a duty by law or custom.

For example, the laws of ancient Babylon controlled wages and hours. Both employers and slavemasters were required to provided for workers during periods of illness and unemployment and to pay their "doctors' fees."

The modern concept of workers' compensation and safety laws originated in Europe as a product of industrialization during the latter part of the nineteenth century. The idea spanned the Atlantic after a generation, and now every state and territory has such a law. Congress has also legislated programs in various areas of activity in interstate and maritime commerce.

Before the enactment of these special laws, the worker's redress for a work injury was limited to a suit for damages against the employer. The worker had the burden of proving that the employer's negligence caused his or her injury, but if the employer could prove that the employee's own negligence played a part in causing the injury, the employee was denied recovery. This special defense, known as the "doctrine of contributory negligence," is a defense in any type of negligence case in most states.

A second defense permitted by the courts was labeled "the fellow-servant rule." Under this rule, if the injury was caused by another employee, the employer was not liable.

The courts also created a third defense known as the "assumption of risk doctrine," which prevented recovery in most cases. The employee was considered as having assumed the risks attendant upon his or her job, and if in the course of regular employment duties the worker was injured, the employer escaped liability. The many uncompensated work injuries caused a serious social and economic situation.

California first dealt with the problem in 1911 by adopting the Roseberry Act, which provided for a voluntary plan of compensation benefits. It was superseded in 1913 by the Boynton Act, which made these benefits compulsory. This enactment, as amended and codified, is the one in force today. Since 1913, then, California workers have been entitled to medical treatment and compensation payments for industrial injuries.

The basic philosophy behind workers' compensation is that industry should provide protection as a cost of doing business and that benefits should be afforded, within defined

limits, regardless of the fault of any person. For this reason, in a compensation case, the defenses of contributory negligence, assumption of risk, and fellow-servant rule are not available to the employer. The law, in turn, provides the employer with protection against negligence suits based on industrial injuries if the employer has provided for compensation benefits. California has also enacted safety laws in an effort to reduce the number of injuries, and many employers and insurance companies maintain staffs of safety experts. These laws are contained in the California Labor Code.

The Labor Code permits both the Administrative Director and the Workers' Compensation Appeals Board, which comprise the Division of Workers' Compensation, to promulgate rules in furtherance of the purposes of the workers' compensation law (Title 8 of the California Code of Regulations).

California has also sought to improve its workers' compensation program through ongoing legislative studies that result in amendments to this law. Study commissions have issued reports in every decade since 1950 and amendatory legislation has resulted. The most far-reaching of such legislation is the Workers' Compensation Reform Act of 1989 (Statutes 1989, chapters 892, 893). This act applies only to injuries occurring on or after its effective date, January 1, 1990, with certain provisions becoming operative in 1991 and 1992. This act changes the name of the Division of Industrial Accidents to Division of Workers' Compensation with sub-offices; a new administrative-medical procedure, operative in 1991, for initial resolution of permanent disability and medical questions; a formalized claims procedure; mandatory arbitration and settlement conferences in certain cases; new time frames for payment of compensation; automatic penalties for late payment; increased monetary benefits; a presumption of spousal dependency in certain death cases; and continuation of death benefit payments to dependent minor children.

For recommendations of national and state study commissions, see chapter 1, section 1.11.

Legislation enacted in 1993 amended many aspects of the workers' compensation law, including increases in compensation along with cost-saving features regarding insurance medical treatment, medical-legal services, procedure, and vocational rehabilitation. These enactments and their effect on the changes made by the 1989 Reform Act, including various operative dates, are discussed topically in appropriate Handbook chapters. As a part of the reform package, the Legislature repealed the minimum premium provisions of the Insurance Code relating to workers' compensation insurance. (See chapter 3, section 3.2) Also adopted were provisions calculated to prevent fraudulent claims. (See chapter 9, section 9.18)

Comprehensive workers' compensation legislation was enacted in 2002, with many of its provisions to take effect on January 1, 2003, unless specified otherwise. By far the most contentious issue was that of increased benefits for injured workers. In addition, the legislation set up a Return-to-Work Program, abolished the presumption of the correctness of the treating physician's findings in many cases, allowed insurers to become more directly involved in setting up workplace safety programs, set forth new rules on settlement and commutation of vocational rehabilitation services, and eliminated "baseball arbitration" (i.e., when WCJ or WCAB must choose between parties' proposed

permanent disability ratings when evaluation of employee conducted by QME), among many other things.

Comprehensive workers' compensation reform was enacted in 2003 as well. Most notable was the fact that the Vocational Rehabilitation Unit was eliminated. A new system of supplemental job displacement benefits was enacted for injuries on or after January 1, 2004. The Industrial Medical Council was also eliminated, and many of the functions and duties of the Council were transferred to the Administrative Director. Other noteworthy reforms included the implementation of HMO-like utilization management tools, an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems, more anti-fraud legislation, caps on chiropractor and physical therapy visits, the use of generic drugs, a three-year pilot for an independent second opinion on recommendations for spinal surgery, an increase in the penalty for an insurance company's late payments to a health care provider, training and skill requirements for workers' compensation claims adjusters, the expansion of alternative workers' compensation dispute resolution, and the listing of insurance companies and rates on the Internet. It remains to be seen if further workers' compensation reform will be enacted in the near future.

The major development in California workers' compensation law during 2004 was enactment of SB 899 (Stats. 2004, Ch. 34), applicable from its date of enactment, April 19, 2004, regardless of the date of injury, unless otherwise specified in the bill (Stats. 2004, Ch. 34, § 47). The bill makes major changes in such areas as medical benefits, temporary disability, permanent disability, apportionment, penalties, return-to-work programs, and more. For example, the bill authorizes insurers and employers to create or modify medical provider networks within which their employees' industrial injuries must be treated. Moreover, the bill has required that the Administrative Director promulgate a medical treatment utilization schedule, whose recommended guidelines will then be presumptively correct on the issue of the extent and scope of medical treatment. Temporary disability payments are limited, with exceptions, to 104 compensable weeks within a period of two years from the date of the first payment. Regarding permanent disability, the bill adds a schedule for converting permanent disability ratings for injuries occurring on or after the effective date of the revised permanent disability schedule to be adopted by the Administrative Director no later than January 1, 2005. In determining percentages of disability, account must be taken of the nature of the physical injury or disfigurement, which must in turn incorporate the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the American Medical Association (AMA) *Guides to the Evaluation of Permanent Impairment* (5th Edition). Statutory treatment of apportionment of permanent disability has been recast, with apportionment now being based on causation, making the employer liable for only the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment. The statutory provisions governing penalties for unreasonable delay or refusal to pay compensation have been amended, applicable to all injuries, regardless of whether the injury occurs before, on, or after the effective date of the statute, making only the amount of the payment unreasonably delayed or refused subject to a penalty of up to 25 percent or $10,000, whichever is less. In the return-to-work programs, payments of wage reimbursement and premium reimbursement have been eliminated.

The following are selected highlights of the reform legislation with a cross-reference to the chapter/section in the Handbook for further discussion:

Medical Provider Networks. In enacting Labor Code §§ 4616–4616.7, the legislature has authorized insurers and employers beginning January 1, 2005, to create or modify medical provider networks within which their employees' industrial injuries must be treated. By November 1, 2004, the Administrative Director is required to adopt regulations implementing the medical provider networks statutes, including regulations that establish procedures for making medical provider network modifications. (For discussion of the regulations, please see § 4.19A.) The medical provider network statutes speak in terms of "economic profiling," which is defined as 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 that person or entity. For a complete discussion of the new medical network laws, including initial medical evaluation and independent medical review, see Ch. 4, § 4.19A. [Note: For a summary of a worker's right to control medical treatment when there is *no* medical provider network in place, see summary highlight of amended Labor Code § 4600, below.]

Two-Year Temporary Disability Cap. In amending Labor Code § 4656, the legislature has provided that, for injuries occurring on or after April 19, 2004, temporary disability payments are limited to 104 compensable weeks within a period of two years from the date of the first payment, with *exceptions* specified for certain injuries and conditions to allow payment of temporary disability to be extended to 240 compensable weeks within five years from the date of injury. [*See* Ch. 5, § 5.10.]

Return-to-Work Program. In amending Labor Code § 139.48, effective July 1, 2004, the legislature has eliminated the payment of wage reimbursement and premium reimbursement from the program, made reimbursements under the program available for an eligible employer only, as defined, and provided that the Return-to-Work Fund will consist of certain penalties and transfers made by the Administrative Director from the Workers' Compensation Administration Revolving Fund. The details of the program are outlined in Ch. 5, § 5.20.

Permanent Disability. In amending Labor Code § 4650, the legislature has provided that, for injuries occurring on or after April 19, 2004, timely payment of permanent disability indemnity, based on a reasonable estimate of the amount due, is to be commenced, regardless of whether the extent of permanent disability can be determined at the date on which the first payment is due. [*See* Ch. 6, § 6.6.] In amending Labor Code §§ 4658 and 4660, and in enacting Labor Code § 4658.1, the legislature has added a schedule for converting permanent disability ratings for injuries occurring on or after the effective date of the revised permanent disability schedule to be adopted by the Administrative Director, no later than January 1, 2005, pursuant to amended Labor Code § 4660. [*See* Ch. 6, § 6.3.] For compensable claims arising before April 30, 2004, the schedule set out in Labor Code § 4658 does *not* apply to the determination of permanent disabilities when there has been either a comprehensive medical-legal report or a report by a treating physician, indicating the existence of permanent disability, or when the employer is required to provide the notice required by Labor Code § 4061 to the injured worker. [*See* Ch. 6, § 6.3.] For a discussion of Labor Code § 4658.1 governing offer

of regular, modified, or alternative work and its effect on permanent disability payments, see Ch. 6, § 6.3. In amending Labor Code § 4660, the legislature has placed various requirements on the Administrative Director regarding periodic revisions of the schedule for the determination of the percentage of permanent disability. In determining the percentages of permanent disability, account must be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of the injury, with consideration being given to en employee's *diminished future earning capacity.* For purposes of this statute, the "nature of the physical injury or disfigurement" must incorporate the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the American Medical Association (AMA) *Guides to the Evaluation of Permanent Impairment* (5th Edition). For compensable claims arising before January 1, 2005, the schedule as revised by legislation during the 2003–2004 Regular and Extraordinary Sessions will apply to the determination of permanent disabilities when there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notice required by Labor Code § 4061 to the injured worker. [*See* Ch. 6, § 6.1.]

Apportionment. In repealing, then adding a new version of, Labor Code § 4663, and in adding Labor Code § 4664, the legislature has recast the statutory treatment of the apportionment of permanent disability, including placement of new responsibilities on physicians who prepare reports addressing the issue of permanent disability due to claimed industrial injury. The new statute provides, among other things, that apportionment of permanent disability is to be based on *causation;* specifically, the employer is liable for only the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment. Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury must in that report address the issue of causation of the permanent disability. An employee who claims an industrial injury must, upon request, disclose all previous permanent disabilities or physical impairments. If the applicant has received a prior award of permanent disability, it will be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof. The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee cannot exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character. For further details, see Ch. 6, § 6.16.

Penalties. In enacting a new version of Labor Code § 5814, effective June 1, 2004, and which is applicable to all injuries, regardless of whether the injury occurs before, on, or after the effective date of the statute, the legislature has provided, among other things, that when payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the *amount of the payment unreasonably delayed or refused* will be increased up to 25 percent or $10,000, whichever is less. If, however, a potential violation of this statute is discovered by the employer prior to an employee claiming a penalty under it, the employer, within 90 days of the date of the discovery, may pay a self-imposed penalty in the amount of 10 percent of the amount of the payment unreasonably delayed or refused, along with the amount of

the payment delayed or refused, in lieu of the 25 percent or $10,000 penalty. No action may be brought to recover penalties that may be awarded under this statute more than two years from the date the payment of compensation was due. In enacting Labor Code § 5814.6, the legislature has provided that any employer or insurer that knowingly violates Labor Code § 5814 with a frequency that indicates a general business practice is liable for administrative penalties not to exceed $400,000. For further details regarding the new laws on penalties, see Ch. 9, § 9.5.

Burden of Proof—Preponderance of the Evidence. The legislature has amended Labor Code § 3202.5 to provide that all parties and lien claimants must meet the evidentiary burden of proof on all issues by a preponderance of evidence in order that all parties are considered equal before the law, and has redefined "preponderance of the evidence" as "that evidence that, when weighed with that opposed to it, has more convincing force and greater probability of truth." [*See* Ch. 14, § 14.6.]

Alternative Dispute Resolution—Collective Bargaining and Labor-Management Agreements. In amending Labor Code §§ 3201.5 and 3201.7, the legislature has provided that alternative dispute resolution procedures in collective bargaining agreements in construction-related industries and in labor-management agreements for any employer or groups of employers that meet certain requirements may allow the parties to negotiate for the delivery of medical benefits and disability compensation to employees who are eligible for group health benefits and non-occupational disability benefits through their employer. [*See* Ch. 3, § 3.4; Ch. 14, § 14.4.]

Vocational Rehabilitation Reinstated for Injuries Before January 1, 2004. In reenacting Labor Code § 139.5, the legislature has reinstated vocational rehabilitation for injuries occurring before January 1, 2004. The reenacted statute will remain in effect only until January 1, 2009, and as of that date is repealed, unless a later-enacted statute, that is enacted before January 1, 2009, deletes or extends that date. [*See* Ch. 16, Special Alert—Vocational Rehabilitation.]

Medical Billing and Provider Fraud—Reporting—Immunity From Civil Action. In amending Labor Code § 3823, the legislature has provided that no party, reporting in good faith what is believed to be a fraudulent claim made by a medical care provider, is subject to any civil liability. [*See* Ch. 9, § 9.18.]

Right to Request Qualified Medical Examination—Disputed Permanent Disability Rating. In amending Labor Code § 4061, the legislature has recast the provisions governing the right of either party to request a qualified medical evaluation in the event of a disputed permanent disability rating. [*See* Ch. 14, § 14.4.]

Objections to Medical Determinations. In amending Labor Code § 4062, the legislature has recast the provisions governing objections by either the employee or the employer to a treating physician's determination of any medical issue not covered by Labor Code § 4060 or 4061 and not subject to the utilization review process pursuant to Labor Code § 4610. [*See* Ch. 14, § 14.4.]

Comprehensive Medical-Legal Evaluations. In amending Labor Code § 4060, the legislature has recast the basic provisions governing entitlement to medical evaluations when compensability of an injury is disputed. [*See* Ch. 14, § 14.4.]

Comprehensive Medical Evaluations—Rights of Unrepresented Employee. In amending Labor Code § 4062.1 by adding new subsections(b)–(e), the legislature has spelled out the procedures to be used when either party seeks appointment of a qualified medical evaluator and the employee is not represented by an attorney. As of April 19, 2004, unrepresented employees must now select a Qualified Medical Examiner from a panel of three medical evaluators to resolve claim disputes. There are also time limits to make the request, to select a medical evaluator from the panel, and to make an appointment. [*See* Ch. 14, § 14.4.]

Comprehensive Medical Evaluations—Rights of Represented Employee. In repealing Labor Code § 4062.2 and adding new Labor Code § 4062.2, the legislature has spelled out the procedures to be used when a comprehensive medical evaluation is required to resolve any dispute arising out of an injury or a claimed injury occurring on or after January 1, 2005, either party seeks appointment of an agreed medical evaluator, and the employee is represented by an attorney. If, however, an Agreed Medical Evaluator is not used, then the parties may request a panel of three Qualified Medical Examiners from which an Agreed Medical Evaluator can be selected. There are also time limits to make the request, to select a medical evaluator from the panel, and to make an appointment. [*See* Ch. 14, § 14.4.]

Panel Qualified Medical Evaluators and Agreed Medical Evaluators—Information and Communication. In adding Labor Code § 4062.3, the legislature has spelled out the rules regarding information to be provided to, as well as communications with, Q.M.E.s selected from a panel and A.M.E.s. [*See* Ch. 14, § 14.4.]

Failure of Qualified Medical Evaluator to Complete Timely Evaluation. In amending Labor Code § 4062.5, the legislature has outlined the consequences for the parties of a Q.M.E.'s failure to complete a timely medical evaluation. [*See* Ch. 14, § 14.4.]

Educational Materials to Train Physicians and Other Providers. In adding Labor Code § 4062.8, the legislature has instructed the Administrative Director to prepare educational materials to be used in training physicians and other providers in relevant aspects of workers' compensation law. [*See* Ch. 1, § 1.8.]

Treating Physician Presumption of Correctness Repealed. In repealing Labor Code § 4062.9, the legislature has deleted the provision that gave a presumption of correctness to the findings of a treating physician or chiropractor who had been designated by an injured worker as his or her personal physician prior to the industrial injury. [*See* Ch. 14, § 14.4.]

Worker's Choice of Physician—No Medical Network—Predesignation of Personal Physician. The legislature has amended Labor Code § 4600 to provide that, unless the employer or the employer's insurer has established a medical provider network as provided for in Labor Code § 4616, an industrially injured worker has the right to select his or her own physician after 30 days from the date on which the injury is reported to the employer. If an employee has notified his or her employer in writing before the date of injury that he or she has a personal physician, the employee has the right to be treated by that physician from the date of injury if the employer provides either nonoccupational group health coverage in a health care service plan or nonoccupational

health coverage in a group health plan or a group health insurance policy. [*See* Ch. 4, § 4.1.]

Medical Treatment—Itemization—Amounts to Be Paid. In amending Labor Code § 4603.2, the legislature has specified that, in general, payments for medical treatment are to be made at reasonable maximum amounts in the official medical fee schedule in effect on the date of service. The legislature has made further amendments throughout Labor Code § 4603.2, including that payment to an employee-selected physician or physician designated by the employer must be made within 45 working days (60 working days if the employer is a governmental entity) after receipt of each separate *itemization* of medical services provided, together with any required medical reports and any written authorization for services that may have been received by the physician. For a complete discussion, see Ch. 4, § 4.19.

Medical Treatment Utilization Schedule—Rebutting Presumption of Correctness. In amending Labor Code § 4604.5, the legislature has provided that, upon adoption of this schedule by the Director, the recommended guidelines set forth in it are to be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the employee from the effects of his or her injury. The presumption created is one affecting the burden of proof. These recommended guidelines are to reflect practices that are evidence and scientifically based, nationally recognized, and peer-reviewed. For all injuries not covered by the Occupational Medicine Practice Guidelines or the official utilization schedule after adoption, authorized treatment is to be in accordance with other evidence-based medical treatment guidelines generally recognized by the national medical community and that are scientifically based. [*See* Ch. 4, § 4.19.]

Medical Treatment Reasonably Required to Cure or Relieve. The legislature amended Labor Code § 4600 to provide that medical treatment "reasonably required to cure or relieve the injured worker from the effects of his or her injury" means treatment that is based on the guidelines adopted by the Administrative Director pursuant to Labor Code § 5307.27 or, prior to the adoption of those guidelines, the updated American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines. [*See* Ch. 4, §§ 4.1, 4.4, 4.15.]

Evidence—Medical Treatment Utilization Guidelines. In amending Labor Code § 5703, the legislature has authorized the W.C.A.B. to receive medical treatment utilization guidelines as evidence. [*See* Ch. 14, § 14.40.]

Medical Treatment Utilization Schedule—Occupational Therapy. In amending Labor Code § 4604.5, the legislature has provided that an employee is entitled to no more than 24 occupational therapy visits per industrial injury. [*See* Ch. 4, § 4.19.]

Filing of Claim Form and Employer's Obligation for Medical Treatment. In amending Labor Code § 5402, the legislature has specified that the employer must provide medical treatment within one working day of the filing of a claim form by an employee and must continue to provide the treatment until the date the claim is accepted or rejected. Until that date, liability for medical treatment is limited to $10,000. Treatment so provided

does not give rise to a presumption of liability on the part of the employer. [*See* Ch. 8, § 8.26; Ch. 14, § 14.2.]

Medical and Hospital Liens—Lien Filing Fee. The legislature amended Labor Code § 4903.05 to provide that a filing fee of $100 is to be charged for each initial lien filed by health care providers, or on behalf of providers, pursuant to Labor Code § 4903(b). [*See* Ch. 10, § 10.3.]

Injury and Illness Prevention Program. The legislature amended Labor Code § 6401.7 to provide that insurers must conduct a review and provide a written report of the injury and illness prevention program of each of its insureds with an experience modification of 2.0 or greater within six months of the commencement of the initial insurance policy term. The reviewer must be or work under the direction of a licensed California Professional engineer, certified safety professional, or a certified industrial hygienist. [*See* Ch. 9, § 9.10.]

Workers' Compensation Funds—Employer Surcharges. In amending Labor Code § 62.5, the legislature has clarified uncertainties generated by apparently conflicting provisions in different pieces of 2003 legislation and provided that the Workers' Compensation Administration Revolving Fund, the Uninsured Employers Benefits Trust Fund, and the Subsequent Injuries Benefits Trust Fund are to be financed exclusively be surcharges levied by the Administrative Director against employers. [*See* Ch. 1, § 1.2.]

Workers' Compensation Insurance Rates. In enacting Labor Code § 138.65, the legislature has provided for a study of the effects of legislative reform on workers' compensation insurance rates and for the Governor and the Insurance Commissioner to make recommendations as to the appropriateness of regulating insurance rates. The legislation requires that the study be submitted by January 1, 2006. [*See* Ch. 1, § 1.2.]

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