

§ 9792.5.4 . Second Review and Independent Bill Review – Definitions

(a) “Amount of payment” means the amount of money owed by the claims administrator for either:

(1) Medical treatment services rendered by a provider in accordance with Labor Code section 4600 that was authorized by Labor Code section 4610, and for which there exists an applicable fee schedule located at sections 9789.10 to 9792.5.3, or 9795.3, or for which a contract for reimbursement rates exists under Labor Code section 5307.11.

(2) Medical-legal expenses, as defined by Labor Code section 4620, where the payment for the services are determined by sections 9793-9795 and 9795.1-9795.4.

(b) “Billing Code” means those codes adopted by the Administrative Director for use in the Official Medical Fee Schedule, located at sections 9789.10 to 989.111, or in the Medical-Legal Fee Schedule, located at sections 9795(c) and 9795(d).

(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, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(d) “Contested liability” means the existence of a good-faith issue which, if resolved against the injured worker, would defeat the right to any workers' compensation benefits or the existence a good-faith issue that would defeat a provider’s right to receive compensation for medical treatment services provided in accordance with Labor Code section 4600 or for medical-legal expenses defined in Labor Code section 9720.

(e) “Consolidation” means combining two or more requests for independent bill review together for the purpose of having the payment reductions contested in each request resolved in a single determination.

(f) “Explanation of review” means the document described in Labor Code section 4603.3 provided by a claims administrator to a provider upon the payment, adjustment, or denial of a complete or incomplete itemization of medical services.

(g) “Independent bill review organization” or “IBRO” means the organization or the organizations designated by the Administrative Director pursuant to Labor Code section 139.5 to perform independent bill review under Labor Code section 4603.6.

(h) “Independent bill reviewer” means an individual retained by the IBRO and subject to the provisions of Labor Code section 139.5 to review a request for independent bill review, with supporting documentation, and issue a determination under the Article.

(i) “Provider” means a provider of medical treatment services whose billing processes are governed by Labor Code section 4603.2, or a provider of medical-legal services whose billing processes are governed by Labor Code sections 4620 and 4622, that has requested independent bill review to resolve a dispute over the amount of payment for services according to either a fee schedule established by the Administrative Director or a contract for reimbursement rates under Labor Code section 5307.11.

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.

Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3, 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.5. Second Review of Medical Treatment Bill or Medical-Legal Bill

(a) If the provider disputes the amount of payment made by the claims administrator on a bill for medical treatment services submitted pursuant to Labor Code section 4603.2, or bill for medical-legal expenses submitted pursuant to Labor Code section 4622, the provider may request the claims administrator to conduct a second review of the bill.

(b) The second review must be requested within 90 days of:

(1) The date of service of the explanation of review provided by a claims administrator in conjunction with the payment, adjustment, or denial of the initially submitted bill, if a proof of service accompanies the explanation of review.

(2) The date of receipt of the explanation of review by the provider, if a proof of service does not accompany the explanation of review and the claims administrator has documentation of receipt.

(3) If the explanation of review is sent by mail and if in the absence of a proof of service or documentation of receipt, the date that is five (5) calendar days after the date of the United States postmark stamped on the envelope in which the explanation of review was mailed.

(4) The date of service of an order of the Workers' Compensation Appeal Board resolving any threshold issue that would preclude a provider's right to receive compensation for the submitted bill.

(c) The request for second review shall be made as follows:

(1) For a medical treatment bill, the second review shall be on either:

(A) The initially reviewed bill, as modified by this subdivision. The bill shall be marked using the National Uniform Billing Committee (NUBC) Condition Code Qualifier "BG" followed by NUBC Condition Code "W3" in the field designated for that information to indicate a request for second review, or

(B) Requested on the Request for Second Bill Review form, DWC Form SBR-1, set forth at section 9792.5.6.

(2) For medical-legal bills, the second review shall be requested on the Request for Second Bill Review form, DWC Form SBR-1, set forth at section 9792.5.6.

(d) The request for second review shall include:

(1) The original dates of service and the same itemized services rendered as the original bill. No new dates of service may be included.

(2) In addition to bill as modified in this subdivision, the second review request shall include, as applicable, the following:

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

(B) The item and amount in dispute.

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

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

(e) If the only dispute is the amount of payment and the provider does not request a second review within the timeframes set forth in subdivision (b), the bill shall be deemed satisfied and neither the claims administrator nor the employee shall be liable for any further payment.

(f) Within 14 days of a request for second review, the claims administrator shall respond to the provider with a final written determination on each of the items or amounts in dispute. The determination shall contain all the information that is required to be set forth in an explanation of review under Labor Code section 4603.3.

(1) The 14-day time limit for responding to a request for second review may be extended by mutual written agreement between the provider and the claims administrator.

(2) Any properly documented itemized service provided and not paid within the 45-day period described in Labor Code section 4603.2(b)(2) shall be paid at the rates then in effect and increased by fifteen (15) percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the provider's initial itemized billing, if the claims administrator untimely communicates the final written determination under this section.

(g) Payment of any balance not in dispute shall be made within 21 days of receipt of the request for second review.

(h) If the provider contests the amount paid after receipt of the final written determination following a second review, the provider shall request an independent bill review pursuant to this Article.

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code

Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.6. Request for Second Review of Bill – Form

Request for Second Bill Review. DWC Form SBR-1.

§ 9792.5.7. Requesting Independent Bill Review.

(a) If the provider disputes the amount of payment made by the claims administrator on a bill for medical treatment services submitted pursuant to Labor Code section 4603.2, or bill for medical-legal expenses submitted pursuant to Labor Code section 4622, following the second review conducted under section 9792.5.5, the provider may request an independent bill review. Unless consolidated under section 9792.5.12, a request for independent bill review shall resolve:

(1) For a bill for medical treatment services, a dispute over the amount of payment billed by a single provider involving one injured employee, one claims administrator, one date of service, and one billing code under the applicable fee schedule adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11 covering one range of effective dates.

(2) For a bill for medical-legal expenses, a dispute over the amount of payment billed by a single provider involving one injured employee, one claims administrator, and one medical-legal evaluation including supplemental reports based on that same evaluation, if any.

(b) Unless as permitted by section 9792.5.12, independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested liability or the applicability of a contract for reimbursement rates under Labor Code section 5307.11 shall be resolved before seeking independent bill review. Issues that are not eligible for independent bill review shall include

(1) The determination of reasonable fee for services where that category of services is not covered by a fee schedule adopted by the Administrative Director or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11.

(2) The proper selection of an analogous code or formula where no fee schedule adopted by the Administrative Director, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11, exists for that category of services unless the fee schedule or contract allows for such analogous coding.

(c) The request for independent bill review must be made within 30 days of:

(1) The date of service of the final written determination issued by the claims administrator under section 9792.5.5(f), if a proof of service accompanies the final written determination.

(2) The date of receipt of the final written determination by the provider, if a proof of service does not accompany the final written determination and the claims administrator has documentation of receipt.

(3) If the final written determination is sent by mail and if in the absence of a proof of service or documentation of receipt, the date that is five (5) calendar days after the date of the United States postmark stamped on the envelope in which the final written determination was mailed.

(4) The date of resolution in favor of the provider of any issue of contested liability.

(5) The date of service of an order of the Workers' Compensation Appeal Board resolving in favor of the provider any threshold issue that would preclude a provider's right to receive compensation for medical treatment services provided in accordance with Labor Code section 4600 or for medical-legal expenses defined in Labor Code section 9720.

(d)(1) The request for independent bill review shall be either by:

(A) Completing and electronically submitting the online Request for Independent Bill Review form, which can be accessed on the Internet at the Division of Workers' Compensation's website. The website link for the online form can be found at <http://www.dir.ca.gov/caibr/htm>. Electronic payment of the required fee of \$325.00 [subject to change] shall be made at the time the request is submitted. Electronic copies of the documents listed in section 9792.5.9(f)(4)(A) may be submitted by the provider with the electronic request form.

(B) Mailing the Request for Independent Bill Review form, DWC Form IBR-1, located in section 9792.5.8, and simultaneously paying the required fee of \$325.00 [subject to change]. Copies of the documents listed in 9792.5.9(f)(4)(A) may be submitted by the provider with the request form.

(2) The provider will include with the request form submitted under this subdivision, either by electronic upload or by mail, a copy of the following documents:

(A) The original billing itemization;

(B) Any supporting documents that were furnished with the original billing;

(C) If applicable, the contract for reimbursement rates under Labor Code section 5307.11.

(D) The explanation of review that accompanied the claims administrator's response to the original billing;

(E) The provider's request for second review of the claims administrator's original response to the billing;

(F) Any supporting documentation submitted to the claims administrator with that request for second review;

(G) The final written determination of the second review issued by the claims administrator to the provider.

(e) The provider may request that two or more disputes that would constitute a separate request for independent bill review be consolidated for a single determination under section 9792.5.12.

(f) The provider shall concurrently serve a copy of the request of independent bill review upon the claim administrator with a copy of the supporting documents submitted under subdivision (d). Any document that was previously provided to the claims administrator or originated from the claims administrator need not be served if a written description of the document and its date is served.

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.

Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3, 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.8. Request for Independent Bill Review Form

Request for Independent Bill Review. DWC Form IBR-1.)

§ 9792.5.9. Initial Review and Assignment of Request for Independent Bill Review to IBRO.

(a) Upon receipt of the Request for Independent Bill Review under section 9792.5.7, the Administrative Director, or his or her designee, shall conduct a preliminary review to determine whether the request is ineligible for review. In making this determination, the Administrative Director shall consider:

(1) The timeliness and completeness of the request;

(2) If a second request for review of the bill was completed;

(3) Whether, for a bill for medical treatment services, the medical treatment was authorized by the claims administrator under Labor Code section 4610.

(4) If the required fee for the review was not paid;

(5) Any previous or duplicate requests for independent bill review of the same bill for medical treatment services or bill for medical-legal expenses.

(6) If the dispute between the provider and the claims administrator is ineligible under section 9792.5.7(b) or contains any other issue than the amount of payment of the bill.

(7) Other reasons, if any, that the application may be ineligible for independent bill review.

(b) If the request appears eligible for review, the Administrative Director, or his or her designee, shall notify the provider and the claims administrator by the most efficient means available that request for independent bill review has been submitted and appears eligible for assignment to an IBRO. The notification shall contain:

(1) A independent bill review case or identification number;

(2) The date the Request for Independent Bill Review, DWC Form IBR-1, was received by the Administrative Director

(3) A statement that within fifteen (15) calendar days of the date designated on the notification, if the notification was provided by mail, or within twelve (12) calendar days of the date designated on the notification if the notification was provided electronically, the Administrative Director, or his or her designee, must receive from the claims administrator any document indicating that the provider's request is ineligible for independent bill review under subdivision (a).

(c) Any document filed with the Administrative Director, or his or her designee, under subdivision (b)(4) must be served on the other party. Any document that was previously

provided to the other party or originated from the other party need not be served if a written description of the document and its date is served.

(c) Upon receipt of the documents requested in subdivision (b)(4), or, if no documents have been received, upon the expiration of fifteen (15) days of the date designated on the notification, if the notification was provided by mail, or within twelve (12) days of the date designated on the notification if the notification was provided electronically, the Administrative Director, or his or her designee, shall conduct a further review in order to make a determination as to whether the request is ineligible for independent bill review under subdivision (a).

(d) If the review conducted under either subdivision (a) or subdivision (c) finds that the request is ineligible for independent bill review, the Administrative Director shall, within fifteen (15) days following receipt of the documents requested in subdivision (b)(4) or, if no documents are received, the expiration of the time period indicated above, issue a written determination informing the provider and claims administrator that the request is not eligible for independent bill review and the reasons therefor.

(1) If a request is deemed ineligible under this section, the provider shall be partially reimbursed the fee provided with the request.

(2) The provider or the claims administrator may appeal an eligibility determination by the Administrative Director by filing a petition with the Workers' Compensation Appeals Board and serving a copy on all interested parties, including the Administrative Director, within 30 days of receipt of the determination.

(e) If the Administrative Director determines from the review conducted under subdivision (c) that the request is eligible for independent medical review, the Administrative Director shall assign the request to an IBRO for an independent bill review. Upon assignment of the request, the IBRO shall notify the parties in writing that the request has been assigned to that organization for review. The notification shall contain:

(1) The name and address of the IBRO;

(2) A independent bill review case or identification number;

(3) Identification of the disputed amount of payment made by the claims administrator on a bill for medical treatment services submitted pursuant to Labor Code section 4603.2, or bill for medical-legal expenses submitted pursuant to Labor Code section 4622,

(f) After the assignment to the IBRO, it shall immediately assign an independent bill reviewer who does not have any material professional, familial, or financial affiliation with any of the individuals, institutions, facilities, services or products as described in Labor Code section 139.5 (c) (2) to review and resolve the dispute.

(g) If in course of conducting an independent bill review it is determined that the bill reviewer assigned to the dispute has a prohibited interest as described in in Labor Code Section 139.5 (c) (2), the IBRO shall reassign the matter to a different independent bill reviewer.

(h) Upon reassignment under subdivision (h), the IBRO shall immediately notify the Administrative Director, the provider, and claims administrator of the reassignment of the dispute to a different independent bill reviewer.

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.

Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3, 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.10. Independent Bill Review - Document Filing

(a) The independent bill reviewer assigned the request shall review all information provided by the parties to determine if any additional information is necessary to resolve the dispute. If the independent bill reviewer determines that additional information is necessary, the independent bill reviewer shall contact the claims administrator and the provider in writing to request the information.

(b) If the independent bill reviewer requests information from either the claims administrator or the provider, or both, the party shall file the documents with the independent bill reviewer at the address listed in the correspondence in Section 9792.5.9(e) within 35 days of the request, if the request is made by mail, or 32 days of the request, if the request is made electronically. The filing party shall serve the non-filing party with the documents requested by the independent bill reviewer.

(C) Except for the documents submitted under this section, and those requested under section 9792.5.12, neither the provider nor the claims administrator shall file any additional documents with the independent bill reviewer.

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.

Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3, 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.11. Withdrawal of Independent Bill Review

(a) Following the submission of all required documents under section 9792.5.10 or 9792.5.12, the provider may withdraw his or her request for independent bill review, before a determination on the amount of payment owed, if the provider and claims administrator settle their dispute regarding the amount of payment of the medical bill. If the provider and claims administrator settle their dispute, they shall make a written joint request for withdrawal and serve it on the independent bill reviewer.

(b) If a request for independent bill review is withdrawn under this section, the provider shall not be reimbursed the fee provided with the request under section 9792.5.7(d).

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.

Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3, 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.12. Independent Bill Review - Consolidation or Separation of Requests

(a) With a request for independent bill review submitted under section 9792.5.7, a provider may request combining two or more requests for independent bill review together for the purpose of having the payment reductions contested in each request resolved in a single determination issued under section 9792.5.14.

(b) In applying this section, the following definitions shall be used:

(1) “Common issues of law and fact” means the denial or reduction of the amount of payment in each request was made for similar reasons and arose from a similar fact pattern material to the reason for the denial or reduction.

(2) “Delivery of similar or related services” means like or coordinated medical treatment services or items provided to one or more injured employees.

(c) Two or more requests for independent bill review by a single provider may be aggregated if the Administrative Director or the IBRO determines that the requests involve common issues of law and fact or the delivery of similar or related services.

(1) Requests for independent bill review by a single provider involving multiple dates of medical treatment services may be consolidated and treated as one single independent bill review request if the requests involve one injured employee, one claims administrator, and one billing code under an applicable fee schedule adopted by the Administrative Director, or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11, and the total amount in dispute does not exceed \$4,000.00.

(2) Requests for independent bill review by a single provider involving multiple billing codes under applicable fee schedules adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11, may be consolidated with no limit on the total dollar amount in dispute and treated as one request if the request involves one injured employee, one claims administrator, and one date of medical treatment service.

(3) Upon a showing of good cause and after consultation with the Administrative Director, the IBRO may allow the consolidation of requests or independent bill review by a single provider showing a possible pattern and practice of underpayment by a claims administrator for specific billing codes. Requests to be consolidated under the subdivision shall involve multiple injured employees, one claim administrator, one billing code, one or multiple dates of service, and aggregated amounts in dispute up to \$4,000.00 or individual amounts in dispute less than \$50.00 each.

(d) Upon filing a request for independent bill review under section 9792.5.7, the provider, if requesting the consolidation of separate requests, shall, in addition to providing the filing fee of \$325.00 [subject to change], specify all of the requests for independent bill review sought to be

aggregated with a description of how the requests involve common issues of law and fact or delivery of similar or related services.

(e) The decision to grant or deny consolidation shall be immediately communicated in writing by the IBRO to the provider and the claims administrator. Once consolidation has been granted no other disputes shall be added to the consolidated disputes.

(f) The IBRO may disaggregate into separate independent bill review requests a single request that does not meet the standards set forth in subdivision (c) of this section. For any independent bill review request that must be disaggregated, the same fee shall be charged for each additional independent bill review request as charged for one independent bill review request.

(1) If an independent bill review request must be separated, the IBRO shall immediately provide notice in writing to the provider and claims administrator stating the reasons for separation, and shall inform the Provider of the additional fee or fees required to perform the independent bill review.

(2) Within ten (10) days following receipt of the notification informing the provider of the separation of requests, the provider shall submit to the IBRO any additional fee or fees necessary to conduct independent bill review. The failure to provide the additional fee or fees shall subject the request to a determination of ineligibility under section 9792.5.9.

(g) Nothing in this section shall extend the time for issuing a determination required by Labor Code section 4603.6 (e).

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.

Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3, 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.13. Independent Bill Review - Review

(a) If the request for independent bill review involves the application of the Official Medical Fee Schedule (OMFS) for the payment of medical treatment services as defined in Labor Code section 4600, the independent bill reviewer shall apply the provisions of sections 9789.10 to 9792.5.3 to determine the additional amounts, if any, that are to be paid to the provider.

(b) If the request for independent bill review involves the application of a contract for reimbursement rates under Labor Code section 5307.11 for the payment of medical treatment services as defined in Labor Code section 4600, the independent bill reviewer shall apply the contract to determine the additional amounts, if any, that are to be paid to the provider.

(c) If the request for independent bill review involves the application of the Medical-Legal Fee Schedule (M/L Fee Schedule) for services defined in Labor Code section 4620, the independent bill reviewer shall apply the provisions of sections 9793-9795 and 9795.1 to 9795.4 to determine the additional amounts, if any, that are to be paid to the provider.

(d) In applying this section, the independent bill reviewer shall apply the provisions of the OMFS, the M/L Fee Schedule, and, if applicable, the contract for reimbursement rates under Labor Code section 5307.11, as if the bill is being reviewed for the first time.

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.

Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3, 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.14. Independent Bill Review - Determination

(a) Within sixty (60) days of the assignment of a dispute to an independent bill reviewer under section 9792.5.9(f), the reviewer shall issue a written determination, in plain language, if any additional amount of money is owed the provider under the request for independent bill review. The determination shall state the reasons for the determination and the information received and relied upon by the independent bill reviewer in rendering the determination.

(b) If the independent bill reviewer finds any additional amount of money is owed to the provider, the determination shall also order the claims administrator to reimburse the provider the amount of the filing fee in addition to any additional payments for services found owing.

(c) The independent bill reviewer shall serve the determination on the provider, the claims administrator and the Administrative Director.

(d) The determination issued by the independent bill reviewer shall be deemed to be the determination of the Administrative Director and shall be binding on all parties.

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.

Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3, 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.15. Independent Bill Review – Implementation of Determination and Appeal.

(a) Upon receiving the determination of the Administrative Director that an additional amount of money is owed to the provider on a bill for medical treatment services submitted pursuant to Labor Code section 4603.2, or bill for medical-legal expenses submitted pursuant to Labor Code section 4622, the claims administrator shall, unless appealed under subdivision (b), pay the additional amounts set forth in the determination per the timely payment requirements set forth in Labor Code sections 4603.2 and 4603.4.

(b) The provider or the claims administrator may appeal a determination of the Administrative Director under section 9792.5.14 by filing a verified petition with the Workers' Compensation Appeals Board and serving a copy on all interested parties, including the Administrative Director, within 20 days of mailing of the determination.

(c) The determination of the Administrative Director shall be presumed to be correct and shall be set aside by the Workers' Compensation Appeals Board only upon proof by clear and convincing evidence of one or more of the following grounds for appeal:

(1) The Administrative Director acted without or in excess of his or her powers.

(2) The determination of the Administrative Director was procured by fraud.

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

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

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

(e) If the final determination of the Administrative Director is reversed on the basis of the criteria set forth in subdivision (c), the dispute shall be remanded to the Administrative Director. The Administrative Director shall:

(1) Submit the dispute to independent medical review by a different IBRO, if available;

(2) If a different IBRO is not available after remand, the Administrative Director shall submit the dispute to the original IBRO for review by a different reviewer in the organization.

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.

Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3, 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.