that it describe specific facts showing the need for immediate action. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 120-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to 180 days.

(c) For compensable claims arising before the effective date of the schedule and any amendment thereto or revision thereof, the revised schedule shall apply to the determination of permanent disabilities where there has either been no comprehensive medical-legal report, or report by a treating physician, indicating the existence of permanent disability, or where the employer is not required to provide the notice required by Section 4061 to the injured worker.

SEC. 44. Section 4663 of the Labor Code is repealed:

~~4663. In case of aggravation of any disease existing prior to a compensable injury; compensation shall be allowed only for the proportion of the disability due to the aggravation of such prior disease which is reasonably attributed to the injury.~~

SEC. 45. Section 4663 is added to the Labor Code, to read:

4663. Apportionment of permanent disability based on causation.

(a) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.

(b) In order for a physician's report to be admissible on the issue of permanent disability, the physician shall determine what percentage of the permanent disability was caused by the direct result of the injury arising out of and occurring in the course of employment and what percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries.

(c) The employer is only liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.

SEC 46. Section 4750 of the Labor Code is repealed:

~~4750. An employee who is suffering from a previous permanent disability of physical impairment and sustains permanent injury thereafter shall not receive from the employer compensation for the later injury in excess of the compensation allowed for such injury when considered by itself and not in conjunction with or in relation to the previous disability or impairment.~~

~~The employer shall not be liable for compensation to such an employee for the combined disability, but only for that portion due to the later injury as though no prior disability or impairment had existed.~~

SEC 47. Section 4750.5 of the Labor Code is repealed:

~~4750.5 An employee who has sustained a compensable injury and who subsequently sustains an unrelated noncompensable injury, shall not receive permanent disability indemnity for any permanent disability caused solely by the subsequent noncompensable injury.~~

~~The purpose of this section is to overrule the decision in Jensen v. WCAB, 136 Cal.App.3d 1042.~~

SEC. 48. Section 5304 of the Labor Code is amended to read:

5304. The appeals board has jurisdiction over any controversy relating to or arising out of Sections 4600 to 4605 inclusive, unless an express agreement fixing the amounts to be paid for medical, surgical or hospital treatment as such treatment is described in those sections has been made between the persons or institutions rendering such treatment and the employer or insurer~~.~~, *or unless the controversy is either subject to independent medical review as set forth in Section 4611 or, for those employees and employers to whom Section 4600 or 4600.31 applies, controversies are determined pursuant to the contract.*

SEC. 49. Section 5307.1 of the Labor Code is amended to read:

5307.1. (a) The administrative director, after public hearings, shall adopt and revise periodically an official medical fee schedule that shall establish reasonable maximum fees paid for medical services ~~other than physician services~~, drugs and pharmacy services, health care facility fees, home health care, and all other treatment, care, services, and goods described in Section 4600 and provided pursuant to this section. Except for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600. Commencing January 1, 2004, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems, except for the components listed in subdivisions (k) and (l), maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services before application of the inflation factors provided in subdivision ~~(e)~~ (g), except that for pharmacy services and drugs that are not otherwise covered by a Medicare fee schedule payment for facility services, the maximum reasonable fees shall be ~~100~~ *110%* percent of fees prescribed in the relevant Medi-Cal payment system. Upon adoption by the administrative director of an official medical fee schedule pursuant to this section, the maximum reasonable fees paid shall not exceed 120 percent of estimated aggregate fees prescribed in the Medicare payment system for the same class of services before application of the inflation factors provided in subdivision ~~(e)~~ (g). Pharmacy services and drugs shall be subject to the requirements of this section, whether furnished through a pharmacy or dispensed directly by the practitioner pursuant to subdivision (b) of Section 4024 of the Business and Professions Code.

(b) In order to comply with the standards specified in subdivision (f), the administrative director may adopt different conversion factors, diagnostic related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.

(c) Notwithstanding subdivisions (a) and (d), the maximum facility fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, may not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department.

(d) If the administrative director determines that a medical treatment, facility use, product, or service is not covered by a Medicare payment system, the administrative director shall establish maximum fees for that item, provided that the maximum fee paid shall not exceed 120