appeals board or a court. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(k) The determination of the independent medical review shall be final and binding upon the parties to the dispute. The determination may not be appealed to the division, a workers' compensation administrative law judge, or the board. Upon a determination by the independent medical treatment review organization that the disputed medical treatment is medically necessary, the employer or other entity shall authorize the disputed medical treatment.

(l) The independent medical review record shall be admissible before the appeals board.

(m) The independent medical review record shall be made available to a qualified medical examiner or an agreed medical examiner if disputes arise over the compensability of the same injury or need for continuing medical treatment as was the subject of the independent medical review. Either party to the dispute over compensability may make the independent medical review available to the QME/AME.

SEC. 39. Section 4614 of the Labor Code is repealed.

~~4614. (a) (1) Notwithstanding Section 5307.1, where the employee's individual or organizational provider of health care services rendered under this division and paid on a fee-for-service basis is also the provider of health care services under contract with the employee's health benefit program, and the service or treatment provided is included within the range of benefits of the employee's health benefit program, and paid on a fee-for-service basis, the amount of payment for services provided under this division, for a work-related occurrence or illness, shall be no more than the amount that would have been paid for the same services under the health benefit plan, for a non-work-related occurrence or illness.~~

~~(2) A health care service plan that arranges for health care services to be rendered to an employee under this division under a contract, and which is also the employee's organizational provider for nonoccupational injuries and illnesses, with the exception of a nonprofit health care service plan that exclusively contracts with a medical group to provide or arrange for medical services to its enrollees in a designated geographic area, shall be paid by the employer for services rendered under this division only on a capitated basis.~~

~~(b) (1) Where the employee's individual or organizational provider of health care services rendered under this division who is not providing services under a contract is not the provider of health care services under contract with the employee's health benefit program or where the services rendered under this division are not within the benefits provided under the employer-sponsored health benefit program, the provider shall receive payment that is no more than the average of the payment that would have been paid by five of the largest preferred provider organizations by geographic region. Physicians, as defined in Section 3209.3, shall be reimbursed at the same averaged rates, regardless of licensure, for the delivery of services under the same procedure code. This subdivision shall not apply to a health care service plan that provides its services on a capitated basis.~~

~~(2) The administrative director shall identify the regions and the five largest carriers in each region. The carriers shall provide the necessary information to the administrative director in the form and manner requested by the administrative director. The administrative director shall make this information available to the affected providers on an annual basis.~~

~~(c) Nothing in this section shall prohibit an individual or organizational health care provider from being paid fees different from those set forth in the official medical fee schedule by an employer, insurance carrier, third-party administrator on behalf of employers, or preferred provider organization representing an employer or insurance carrier provided that the administrative director has determined that the alternative negotiated rates between the organizational or individual provider and a payer, a third-party administrator on behalf of employers, or a preferred provider organization will produce greater savings in the aggregate than if each item on billings were to be charged at the scheduled rate.~~

~~(d) For the purposes of this section, "organizational provider" means an entity that arranges for health care services to be rendered directly by individual caregivers. An organizational provider may be a health care service plan, disability insurer, health care organization, preferred provider organization, or workers' compensation insurer arranging for care through a managed care network or on a fee-for-service basis. An individual provider is either an individual or institution that provides care directly to the injured worker.~~

SEC. 40. Section 4614.1 of the Labor Code is repealed.

~~4614.1. Notwithstanding subdivision (f) of Section 1345 of the Health and Safety Code, a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act and certified by the administrative director pursuant to Section 4600.5 to provide health care pursuant to Section 4600.3 shall be permitted to accept payment from a self-insured employer, a group of self-insured employers, or the insurer of an employer on a fee-for-service basis for the provision of such health care as long as the health care service plan is not both the health care organization in which the employee is enrolled and the plan through which the employee receives regular health benefits.~~

SEC. 41. Section 4658 of the Labor Code is amended to read:

4658. (a) For injuries occurring prior to January 1, 1992, if the injury causes permanent disability, the percentage of disability to total disability shall be determined, and the disability payment computed and allowed, according to paragraph (1). However, in no event shall the disability payment allowed be less than the disability payment computed according to paragraph (2).

(1)

Column 1--Range of percentage of permanent disability incurred:	Column 2--Number of weeks for which two-thirds of average weekly earnings allowed for each 1 percent of permanent disability within percentage range:
Under 10	3
10-19.75	4
20-29.75	5
30-49.75	6