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**Title 8 California Code of Regulations  
Chapter 4.5. Division of Workers' Compensation  
Subchapter 1. Administrative Director -- Administrative Rules**

**Article 3.5. Medical Provider Networks**

**Section 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, including, but not limited to, interpreter services, physical therapy and pharmaceutical services.

(2) “Contracting Agent” is a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, a disability insurer licensed by the California Department of Insurance, a third-party administrator with a certificate to administer by the California Department of Insurance, a health care service plan, including a specialized health care service plan, a preferred provider organization as defined in title 5 California Code of regulations section 4610, a self-insured employer approved by the Office of Self-Insured Plans (OSIP), an approved health care organization certified in accordance with Labor Code section 4600.5 and a medical provider network approved by the Administrative Director in accordance with Labor Code section 4616.

~~(2)~~ (3) “Covered employee” means an employee or former employee whose employer has ongoing workers' compensation obligations and whose employer or employer's insurer is using 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 or 3201.81.

~~(3)~~(4) “Division” means the Division of Workers' Compensation.

~~(4)~~(5) “Electronic address” or “Electronic Service Address” means an email address, document download address or service, or other electronic or physical repository capable of receiving electronic transmissions that must be encrypted to protect the integrity of the transmission.

~~(6)~~ “Electronic Signature” means a signature as defined by Civil Code section 1633.2 or a digital signature as defined by Government Code section 16.5. An electronic signature shall be accompanied by the date upon which the electronic signature was executed on the document containing the electronic signature.

~~(4)~~(7) “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.

~~(5)~~(8) “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.

~~(6)~~(9) “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.

~~(7)~~(10) “Entity that provides physician network services” means a legal entity employing or contracting with physicians and other medical providers or contracting with physician networks, and may include but is not limited to third party administrators and managed care entities, to deliver medical treatment to injured workers on behalf of one or more insurers, self-insured employers, the Uninsured Employers Benefits Trust Fund, the California Insurance Guaranty Association, or the Self-Insurers Security Fund, and that meets the requirements of this article, Labor Code 4616 et seq., and corresponding regulations.

~~(8)~~(11) “Geocoding” means the mapping of addresses within specific geographic location(s) or coordinate space.

~~(9)~~(12) “Group Disability Insurance Policy” means an entity designated pursuant to Labor Code section 4616.7(c).

~~(10)~~(13) “Health Care Organization” means an entity designated pursuant to Labor Code section 4616.7(a).

~~(11)~~(14) “Health Care Service Plan” means an entity designated pursuant to Labor Code section 4616.7(b).

~~(12)~~(15) “Health care shortage” means a situation in a geographical area in which the number of physicians in a particular specialty who are available and willing to treat injured workers under the California workers’ compensation system is insufficient to meet the Medical Provider Network access standards set forth in 9767.5(a) through (c) to ensure medical treatment is available and accessible at reasonable times. A lack of physicians participating in an MPN does not constitute a health care shortage where a sufficient number of physicians in that specialty are available within the access standards and willing to treat injured workers under the California workers’ compensation system.

~~(13)~~(16) “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.

(17) “Medical Practice Group” means two or more providers who provide medical care within the same facility, they utilize the same personnel and divide the income in a manner previously agreed upon by the group.

~~(14)~~(18) “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.

~~(15)~~(19) “Medical Provider Network Identification Number” means the unique number assigned by DWC to a Medical Provider Network upon approval ~~or within ninety (90) days of the effective date of these regulations and used to identify each approved~~ Medical Provider Network.

~~(16)~~(20) “Medical Provider Network Medical Access Assistant” means an individual in the United States provided by the Medical Provider Network to help injured workers with finding available Medical Provider Network physicians of the injured workers’ choice and with scheduling provider appointments.

~~(17)~~(21) “Medical Provider Network Geographic Service Area” means the geographic area within California in which medical services will be provided by the Medical Provider Network.

~~(18)~~(22) “Medical Provider Network Plan” means an employer's, insurer's, or entity that provides physician network services’ detailed description for a Medical Provider Network contained in a complete application submitted according to the requirements of this article to the Administrative Director by an MPN Applicant.

~~(19)~~(23) “MPN Applicant” means an insurer or employer or an entity that provides physician network services as defined in this section who is legally responsible for the Medical Provider Network.

~~(20)~~ (24) “MPN Contact” means an individual(s) designated by the MPN Applicant in the employee notification who is responsible for responding to complaints, for answering employees' questions about the Medical Provider Network and for assisting the employee in arranging for an MPN independent medical review pursuant to Labor Code section 4616.4.

~~(21)~~(25) “Occupational Medicine” means the diagnosis or treatment of any injury or disease arising out of and in the course of employment.

(26) “Participating provider” means a physician as described in Labor Code section 3209.3 and other practitioner as described in Labor Code section 3209.5 and Ancillary services.

~~(22)~~(27) “Primary treating physician” means a primary treating physician within the medical provider network and as defined by section 9785(a)(1).

~~(23)~~(28) “Probation” means a Medical Provider Network’s approval is conditioned on the completion of specified actions within a stated time frame as required by the Administrative Director for the Medical Provider Network to comply with the requirements of this article and Labor Code sections 4616 et seq.

~~(24)~~(29) “Provider” means a physician as described in Labor Code section 3209.3 or other practitioner as described in Labor Code section 3209.5.

~~(25)~~(30) “Regional area listing” means either:

(A) a listing of all MPN providers within a 15-mile radius of an employee's worksite or residence; or

(B) a listing of all MPN providers in the county where the employee resides or works if

1. the employer or insurer or claims administrator cannot produce a provider listing based on a mile radius

2. or by choice of the employer or insurer or claims administrator, 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.

(31) "Remote service" means mode of delivering medical services or goods as allowed in Labor Code section 4600 by a non-physician, including, but not limited to, interpreter services and pharmaceutical services via information and communication technologies to facilitate the diagnosis, consultations, treatment, education, care management and self-management of a patient's health care while the patient is at the originating site and the ancillary service provider is at the distant site, this mode of health care shall be in compliance with all state and federal laws including privacy laws.

~~(26)~~(32) "Residence" means the covered employee's primary residence.

~~(27)~~(33) "Revocation" means the permanent termination of a Medical Provider Network's approval.

~~(28)~~(34) "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, pursuant to Labor Code section 4616.3.

~~(29)~~(35) "Suspension" means the temporary discontinuance of MPN coverage for new claims within a specified period as required by the Administrative Director.

~~(30)~~(36) "Taft-Hartley health and welfare fund" means an entity designated pursuant to Labor Code section 4616.7(d).

(37) "Telehealth" means a mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultations, treatment, education, care management and self-management of a patient's health care while the patient is at the originating site and the physician is at the distant site, this mode of health care shall be done by a California licensed physician and in compliance with all state and federal laws including privacy laws.

~~(34)~~(38) "Termination" means the permanent discontinued use of an implemented MPN that ceases to do business.

~~(32)~~(39) "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, pursuant to Labor Code section 4616.3.

~~(33)~~(40) "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.

~~(34)~~(41) "Withdrawal" means the permanent discontinuance of an approved MPN that was never implemented.

~~(35)~~(42) "Workplace" means the geographic location where the covered employee is regularly employed.

Authority: Sections 133 and 4616(h), Labor Code.

Reference: Sections 1063.1, 3208, 3209.3, 3209.5, 3700, 3702, 3743, 4609, 4616, 4616.1, 4616.3, 4616.5 and 4616.7, Labor Code; and *California Insurance Guarantee Association v. Division of Workers' Compensation* (April 26, 2005) WCAB No. Misc. #249.

## **Section 9767.2. Review of Medical Provider Network Application or Plan for Reapproval.**

(a) Within 60 days of the Administrative Director's receipt of a complete new application, the Administrative Director shall approve for a four-year period or disapprove a new application based on the requirements of Labor Code section 4616 et seq. and this article. An application shall be considered complete if it includes correct 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 new application plan within 60 days of submittal of a complete plan, it shall be deemed approved on the 61<sup>st</sup> day for a period of four years.

(b) Within 180 days of the Administrative Director's receipt of a complete plan for reapproval, the Administrative Director shall approve for a four-year period or disapprove the complete plan for reapproval based on the requirement of Labor Code section 4616 et seq. and this article. A plan for reapproval shall be considered complete if it includes correct information responsive to each applicable subdivision of section 9767.3. If the Administrative Director has not acted within 180 days of receipt of a complete plan for reapproval, it shall be deemed approved on the 181<sup>st</sup> day for a period of four years.

(c) The Administrative Director shall provide notification(s) to the MPN applicant: (1) setting forth the date the MPN application or reapproval plan was received by the Division; (2) informing the MPN applicant if the MPN application or reapproval plan is not complete and the item(s) necessary to complete the application or reapproval plan; and (3) if the Administrative Director is aware that the MPN applicant is not eligible to have an MPN.

(d) 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 (c).

(e) The Administrative Director's decision to approve or disapprove an application shall be limited to his/her their review of the information provided by the MPN applicant in the application or reapproval plan or additional information and documentation as requested by the Administrative Director.

(f) Upon approval of a new Medical Provider Network Plan, the MPN shall be assigned a unique MPN Identification number. This unique MPN Identification number shall be used in all correspondence with DWC regarding the MPN, including but not limited to future filings and complaints, and shall be included in the complete employee notification, transfer of care notice, continuity of care notice, MPN IMR notice and end of MPN coverage notice.

(g) An MPN applicant may choose to withdraw an approved MPN that has never been implemented by sending a letter signed by the MPN's authorized individual to the Administrative Director with the name and approval number of the MPN to be withdrawn, and a statement verifying that the MPN has never been used and that the MPN applicant will not use the MPN in the future.

(h) An MPN applicant may choose to terminate an approved MPN that was implemented and no longer in use by transmitting a letter signed by the MPN applicant's authorized individual to the Administrative Director with the name and MPN identification number to be terminated. The termination letter shall include the termination effective date, affirmation of any covered employees being notified of the termination and continuity of care plan prior to the termination of the MPN.

Authority: Sections 133 and 4616(h), Labor Code.

Reference: Section 4616, Labor Code.

### **Section 9767.3. Requirements 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 or entity that provides physician network services from submitting for approval one or more medical provider network applications.

(b) Nothing in this section precludes an MPN applicant 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 complete the section 9767.4 Cover Page for Medical Provider Network Application or Plan for Reapproval with an original signature or electronic signature, and an MPN Plan meeting the requirements of this section or the optional MPN Plan Application form. ~~Two copies~~ One copy of the completed, signed Cover Page for Medical Provider Network Application or Plan for Reapproval and the complete MPN Plan shall be submitted to the DWC in compact discs or flash drives or to an electronic address in word-searchable PDF format. The hard copy of the completed, signed original Cover Page for Medical Provider Network Application or Plan for Reapproval and the complete MPN Plan shall be maintained by the MPN applicant and made available for review by the Administrative Director upon request. Electronic signatures ~~in compliance with California Government Code section 16.5~~ are accepted. If the MPN provides a written statement under penalty of perjury that the MPN Plan name and MPN Identification number submitted and approved by the DWC on a specific date has not changed the DWC will accept the cover page, an updated roster of all treating physicians and all statewide participating providers. The prior approved plan does not need to be resubmitted. This submission including the previously approved plan will be subject to a review in accordance with statutes and regulations.

(1) An MPN applicant shall submit the MPN provider information and ancillary service provider information required in section 9767.3(d)(8)(G) and (I) in a compact disc(s) or, a flash drive(s) or to an electronic address. The information shall be submitted as a Microsoft Excel spread sheet unless an alternative format is approved by the Administrative Director. If the MPN applicant is using a valid and currently certified Health Care Organization, then this information must be noted on the application's Cover Page for Medical Provider Network or Plan for Reapproval and only a listing of any additional ancillary service providers is required to be submitted pursuant to the requirements in subsection (3) of this subdivision.

(2) The network provider information shall be submitted in a compact disc(s), or a flash drive(s), or to an electronic address and the provider file shall have ~~only~~ eight ~~eight~~ nine columns. These columns shall be in the following order: (1) physician name (2) specialty (3) physical address (4) city (5) state (6) zip code (7) any MPN medical



group affiliations and (8) an assigned provider code for each physician listed (9) physician license number. If a physician falls under more than one provider code, the physician shall be listed separately for each applicable provider code. The following are the provider codes to be used: primary treating physician (PTP), orthopedic medicine (ORTHO), chiropractic medicine (DC), occupational medicine (OCCM), acupuncture medicine (LAC), psychology (PSYCH), pain specialty medicine (PM), psychiatry (PSY), neurosurgery (NSG), family medicine (GP), neurology (NEURO), internal medicine (IM), physical medicine and rehabilitation (PMR), or podiatry (DPM). If the specialty does not fall under any one of the previously listed categories, then the specialty shall be clearly identified in the specialty column and the code used shall be (MISC). By submission of its provider listing, the applicant is affirming that all of the physicians listed have been informed that the Medical Treatment Utilization Schedule ("MTUS") is presumptively correct on the issue of the extent and scope of medical treatment and diagnostic services and have a valid and current license number to practice in the State of California. If the physician is providing telehealth services only the office address filed with the physician's licensing board shall be used and an additional column shall be provided to indicate the geographic service area in California to be serviced by the telehealth provider.

(3) If an MPN chooses to provide ancillary services, the ancillary service provider file shall have ~~only~~ the following ~~six~~ seven columns. The columns shall be in the following order: (1) the name of each ancillary service provider (2) specialty or type of service (3) physical address (4) city (5) state (6) zip code of each ancillary service provider (7) license number with a board or bureau of the California Department of Consumer Affairs or business registration identification with the Secretary of State or evidence of certification/license with the California Department of Public Health or for interpreters certification as provided for in Labor code section 4600(g) and the Administrative Director's regulations regarding interpreter services. ~~If the ancillary service or ancillary service provider is mobile, list the covered service area within California. If the ancillary service provider is providing remote services an office address must be listed. The provider shall list the office address filed and approved by the California Secretary of State or other accrediting licensing board as stated above and an additional column shall be provided to indicate the geographic service area in California to be serviced by the remote service provider.~~ By submission of an ancillary provider listing, the applicant is affirming that the providers listed can provide the requested medical services or goods and have a current valid license number or certification to practice, if they are required to have a license or certification by the State of California. ~~If interpreter services are included as an MPN ancillary service, the interpreters listed must be certified pursuant to section 9795.1.6(a)(2)(A) and (B).~~

(4) An MPN determines which locations are approved for physicians to provide treatment under the MPN. Approved locations are listed in an MPN's provider listing; however, an MPN has the discretion to approve treatment at non-listed locations.

(5) An MPN applicant shall have the exclusive right to determine the members of its network.

(d) A Medical Provider Network application shall include all of the following information:

(1) Type of Eligible MPN applicant. Provide a description of the entity's qualifications to be an eligible MPN Applicant. Attach proof of MPN eligibility. If a self-insured employer or joint powers authority, attach a copy of the current valid certificate of self-insurance. For an insurer, attach a current valid certificate of authority. For an entity providing physician network services, attach documentation of current legal status including, but not limited to, legal licenses or certificates and affirm that the entity employs or contracts with physicians and other medical providers or contracts with physician networks.

(2) Name of MPN applicant.

(3) MPN applicant's Taxpayer Identification Number.

(4) Name of Medical Provider Network.

(5) MPN Liaison to DWC: 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 eligible MPN applicant.

(8) Description of Medical Provider Network Plan:

(A) Affirm that the MPN network is adequate to handle the expected number of claims covered under the MPN and explain how this was determined;

(B) Describe the MPN geographic service area or areas within the State of California to be served;

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(C) State the toll-free number, email address, fax number and days and times of availability to reach the MPN's medical access assistants.

(D) State the MPN website address;

(E) State the web address or URL to the roster of all treating physicians in the MPN. Affirm that secondary treating physicians who are counted when determining access standards but can only be seen with an approved referral are clearly designated "by referral only". The roster of treating physicians shall include, at a minimum, the name of each individual provider and provider office address and provider office telephone number. If the treating physician is providing telehealth services the geographic service area in California to be serviced by the telehealth provider shall be provided and indicate if telehealth only is being offered by the physician.

(F) Affirm that each MPN physician or medical group in the network has agreed to treat workers under the MPN and that the written acknowledgments are in accordance with the requirements under "Physician Acknowledgments" section 9767.5.1, and are available for review by the Administrative Director upon request;

(G) Provide a listing of the name, specialty, and location of each physician as described in Labor Code Section 3209.3, who will be providing occupational medicine services under the plan. Only individual physicians in the MPN shall be listed, but MPN medical group affiliation(s) may be included with each individual physician listed. 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.

(H) Provide an electronic copy in Microsoft Excel format of the geocoding results of the MPN provider directory to show estimated compliance with the access standards set forth in section 9767.5. Telehealth only providers shall not be considered in the access standards calculation for the MPN application as they do not meet the requirements of Business and Professions code section 2290.5. A judge or the Workers' Compensation Appeals board may consider telehealth only providers in a determination as to access standards. The access standards set forth in section 9767.5 are determined by the injured employee's residence or workplace address and not the center of a zip code. The geocoding results will be used by DWC in reviewing MPN plans to give an approximation of MPN compliance with the access standards set forth in section 9767.5. The geocoding results shall include the following separate files summarizing data reasonably available at the time of compilation: 1) a complete list of all zip codes within the MPN geographic service area; 2) a narrative or graphic report that establishes where there are at least three available primary treating physicians within the fifteen-mile access standard from the center of each zip code within the MPN geographic service area; 3) a narrative or graphic report that establishes where there is a hospital

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or an emergency health care service provider within the fifteen-mile access standard from the center of each zip code within the MPN geographic service area; 4) a narrative or graphic report that establishes where there are at least three available physicians in each of the specialties commonly required to treat injured workers covered by the MPN within the thirty-mile access standard from the center of each zip code within the MPN geographic service area; 5) a list of all zip codes where access standards are not met in the geographic service area or areas to be served by the MPN for primary treating physicians, for acute care hospitals or emergency facilities, and for each specialty listed to treat common injuries experienced by injured workers covered by the MPN, and a narrative report explaining if medical treatment will be provided according to an approved alternative access standard or according to a written policy permitting out of MPN treatment in those areas; and 6) each physician listed in the MPN provider directory listing shall be assigned at least one provider code as set forth in subdivision (c)(2) of this section to be used in the geocoding reports;

(I) If an MPN chooses to include ancillary services in its network, a listing of the name, specialty or type of service and location of each ancillary service, other than a physician covered under subdivision (d)(8)(G) of this section, who will be providing services or goods 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 and that the ancillary services will be available at reasonable times and within a reasonable geographic area to covered employees;

(J) If the MPN includes ancillary services in its network, state the web address or URL to the roster of all ancillary services in the MPN. The roster of ancillary services shall include, at a minimum, the name of each individual provider and their office address and their office telephone number, type of service provided and location of the services. If the ancillary service is provided by an entity rather than an individual, then that entity's name, address and telephone number shall be listed. If the ancillary service is providing remote services the geographic service area in California to be serviced by remote service shall be provided and indicate if remote service only is being offered by the ancillary service.

~~(J)~~(K) Describe how the MPN provides ancillary services to its covered employees. Set forth which ancillary services, if any, will be within the MPN. For ancillary services not able to be provided within the MPN pursuant to section 9767.5(d), affirm that referrals will be made to services outside the MPN;

~~(K)~~(L) Describe how the MPN complies with the second and third opinion process set forth in section 9767.7;

~~(L)~~ (M) Describe how the MPN complies with the access standards set forth in section 9767.5 for all covered employees;

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~~(M)~~ (N) Describe the employee notification process, and attach an English and Spanish copy of the required employee notification material and information to be given to covered employees described in sections 9767.12(a);

~~(N)~~ (O) Attach a copy of the written continuity of care policy as described in Labor Code section 4616.2;

~~(O)~~ (P) Attach a copy of the written transfer of care policy that complies with section 9767.9;

~~(P)~~ (Q) 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;

~~(Q)~~ (R) 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

~~(R)~~ (S) 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.

~~(S)~~ (T) Describe the MPN’s procedures, criteria and how data is used to continuously review quality of care and performance of medical personnel, utilization of services and facilities, and costs. Describe on the MPN website how to apply to be in the MPN or if not currently accepting new providers a statement that the MPN is not currently accepting new providers. Describe on the MPN website how a participating provider can request to be removed from the MPN.

~~(T)~~ (U) Affirm that ~~as of January 1, 2013,~~ every contracting agent that sells, leases, assigns, transfers, or conveys its medical provider networks and their contracted reimbursement rates to an insurer, employer, or entity that provides physician network services, or to another contracting agent shall, insure that the contract between the contracting agent, employer or carrier and the health care provider or health facility provides for an express agreement as to the complete list of the employers, contracting agents and insured that are subject to the agreement and rate under the contract. The contracted reimbursement rates must be established through an express agreement. The medical provider network that provides the Complete Employee Notification to the injured worker must also inform the participating provider of that medical provider network of all notice requirements of Labor Code section 4609. upon entering or

~~renewing a provider contract, disclose to the provider whether the medical provider network may be sold, leased, transferred, or conveyed to other insurers, employers, entities providing physician network services, or another contracting agent, and specify whether those insurers, employers, entities providing physician network services, or contracting agents include workers' compensation insurers.~~

(e) 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 (d) 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.

(f) 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.

(g) 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).

(h) 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.

Authority: Sections 133 and 4616(h), Labor Code.

Reference: Sections 3209.3, 4609, 4616, 4616.1, 4616.2, 4616.3, 4616.5 and 4616.7, Labor Code and Section 16.5, Government Code.

**Section 9767.4. Cover Page for Medical Provider Network Application or Plan for Reapproval.**

For DWC only: MPN Identification Number      Date Application Received:    /    /

**Cover Page for Medical Provider Network Application or Plan for Reapproval**

1. Legal Name of MPN Applicant \_\_\_\_\_

2. MPN Applicant Address    3. Tax Identification Number \_\_\_\_ -- \_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Eligibility Status of MPN Applicant

- ☐ Self-Insured Employer (including SISF) ☐ Insurer (including CIGA, UEBTF) ☐ Group of Self-Insured Employers
- ☐ Joint Powers Authority                      ☐ State
- ☐ Entity that provides physician network services

5. Name of Medical Provider Network \_\_\_\_\_

6. If the medical provider network is using one of the following deemed entities, check the appropriate box:

- ☐ Health Care Organization (HCO)
- ☐ Health Care Service Plan
- ☐ Group Disability Insurer
- ☐ Taft-Hartley Health and Welfare Trust Fund

7. Is this a plan for reapproval? ☐ Yes ☐ No    If Yes, include date of last MPN approval and MPN Identification Number:

\_\_\_\_\_

8. MPN Website Address:

\_\_\_\_\_

9. MPN Provider Listing Web

Address: \_\_\_\_\_

10. Initial here if you certify that the prior MPN application approved on (date) has not changed and you are requesting that the DWC accept the prior approved application in this reapplication. The prior approved application maybe re-reviewed by the DWC.

Initials of Authorization Individual

~~10.11.~~ Signature of authorized individual: "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."

Name of Authorized Individual	Title
Phone	Email
Signature of Authorized Individual	Date Signed

~~11.12~~ Authorized Liaison to DWC:

Name	Title	Organization
Phone	Email	
Address	Fax number	

Submit ~~two~~ one ~~copies~~ of the completed, signed Cover Page for Medical Provider Network Application or Plan for Reapproval and the complete MPN Plan electronically to DWC Medical Unit or in compact discs or flash drives in word searchable PDF format to the Division of Workers' Compensation. Mailing address: DWC, MPN Application, P.O. Box 71010, Oakland, CA 94142.

[DWC Mandatory Form - Section 9767.4 - [05/14]

Authority: Sections 133 and 4616(h), Labor Code.

Reference: Sections 3700, 3743, 4616, 4616.5 and 4616.7, Labor Code.



## **Section 9767.5. Access Standards.**

(a) A MPN must have at least three available physicians of each specialty 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 (1) and (2).

(1) An MPN must have at least three available primary treating physicians 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.

(2) An MPN must have providers of occupational health services and specialists who can treat common injuries experienced by the covered injured employees within 60 minutes or 30 miles of a covered employee's residence or workplace.

(b) If an MPN applicant believes that, given the facts and circumstances with regard to a portion of its service area, specifically areas in which there is a health care shortage, including non-rural areas and rural areas in which health facilities are located at least 30 miles apart, the accessibility standards set forth in subdivisions (a)(1) and/or (a)(2) cannot be met, 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 application or in a notice of MPN plan modification and shall be reviewed and approved by the Administrative Director before the alternative standard can be used. The applicant shall explain how the proposed alternative standard was determined to be necessary for the specialty(ies) in which there is a health care shortage, including a description of the geographic area(s) affected for each specialty at issue, how the applicant determined a physician shortage exists in each area and specialty how the alternative access distance was determined and why it is necessary. The alternative standards shall provide that all services shall be available and accessible at reasonable times to all covered employees.

(c) If a covered employee is not able to obtain from an MPN physician reasonable and necessary medical treatment within the applicable access standards in subdivisions (a) or (b) and the required time frames in subdivisions (f) and (g), then the MPN shall have a written policy permitting the covered employee to obtain necessary treatment for that injury from an appropriate specialist outside the MPN within a reasonable geographic area. When the MPN is able to provide the necessary treatment through an MPN physician, a covered employee treating outside the MPN may be required to treat with an MPN physician when a transfer is appropriate.

(d) A workers' compensation judge or the Workers' Compensation Appeals Board may determine that an injured worker may seek treatment outside the MPN if the MPN does not have at least 3 primary treating physicians from a different medical practice group.

~~(d)~~(e) If an MPN provides ancillary services and those services or goods are not available within a reasonable time or a reasonable geographic area to a covered employee, then the employee may obtain necessary ancillary services outside of the MPN within a reasonable geographic area.

~~(e)~~(f)(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 a list 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 (a) of this section.

(4) Nothing in this section precludes a covered employee outside the MPN geographic service area from choosing his or her own provider for non-emergency medical care.

~~(f)~~(g) For non-emergency services, the MPN applicant shall ensure that an appointment for the first treatment visit under the MPN is available within 3 business days of a covered employee's notice to an MPN medical access assistant that treatment is needed.

~~(g)~~(h) 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 initial appointment with a specialist in an appropriate referred specialty is available within 20 business days of a covered employee's reasonable requests for an appointment through an MPN medical access assistant. If an MPN medical access assistant is unable to schedule a timely medical appointment with an appropriate specialist within ten business days of an

employee's request, the employer shall permit the employee to obtain necessary treatment with an appropriate specialist outside of the MPN.

~~(h)~~(i) MPN medical access assistants shall be located in the United States and shall be available, at a minimum, from Monday through Saturday from 7 am to 8 pm, Pacific Time, to provide employee assistance with access to medical care under the MPN. The employee assistance shall be available in English and Spanish. The assistance shall include but not be limited to contacting provider offices during regular business hours and scheduling medical appointments for covered employees. The MPN medical access assistant shall have the ability to schedule an appointment within the network. The MPN medical access assistant or the employer or insurer or claims administrator shall provide to the selected provider written authorization within 5 days of scheduling the appointment or send notice to the provider and all parties a written objection to the appointment providing a basis for the objection.

(1) There shall be at least one MPN medical access assistant available to respond at all required times, with the ability for callers to leave a voice message. There shall be enough medical access assistants to respond to calls, faxes or messages by the next day, excluding Sundays and holidays.

(2) MPN medical access assistants have different duties than claims adjusters. MPN medical access assistants work in coordination with the MPN Contact and the claims adjuster(s) to ensure timely and appropriate medical treatment is provided to the injured worker. The MPN medical access assistant shall have the authority to schedule an appointment for the injured worker within the network. The MPN medical access assistant or the employer or insurer or claims administrator shall provide to the selected provider written authorization within 5 days of scheduling the appointment or send notice to the provider and all parties written objection to the appointment providing a basis for the objection. Although their duties are different, if the same person performs both, the MPN medical access assistant's contacts must be separately and accurately logged.

~~(j)~~(i) 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.

~~(j)~~(k) 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.

Authority: Sections 133 and 4616(h), Labor Code.  
Reference: Sections 4616 and 4616.3, Labor Code.

## **Section 9767.5.1. Physician Acknowledgments.**

(a) An MPN applicant shall obtain from each physician participating in the MPN a written acknowledgment in which the physician affirmatively elects to be a member of the MPN as provided in this section. This section does not apply to a physician who is a shareholder, partner, or employee of a medical group that elects to participate in the MPN, however this section applies to the medical group that elects to participate in the MPN.

(b) The following persons may execute the acknowledgment:

(1) If the acknowledgment is for one or more physicians, it shall be executed by:

(A) The physician(s); or

(B) An employee of the physician or an employee of the physician's office; or

(C) If authorized by the physician(s), an agent or representative of a medical group.

(2) If a medical group elects to participate in an MPN, an authorized officer or agent of the medical group shall execute the acknowledgment. Unless the acknowledgment is for all physicians who are shareholders, partners, or employees of a medical group, or all physicians in a distinct department or unit of the medical group, the acknowledgement shall include or refer to a list of the participating physicians, and the officer or agent shall update the list within 90 days of any additions to or removals from the list.

(c) A written acknowledgment must provide a date upon which the signature was executed and may be in any of the following forms:

(1) A tangible document bearing an original signature, or a facsimile or electronic image of the original document and signature.

(2) An electronically signed document in compliance with Government Code section 16.5 or Civil Code sections 1633.1 et seq. whichever is applicable.

(3) An electronic acknowledgment using generally accepted means of authentication to confirm the identity of the person making the acknowledgment.

(d) The acknowledgement shall identify the MPN in which the physician or group participates. Multiple MPNs may be identified in a single acknowledgment or separate acknowledgments or in any combination. Any form that presents more than one MPN  
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for the physician's acknowledgment shall enable the physician either to opt in or to opt out of each MPN. The MPN or MPNs may be identified by reference to a website listing where a person described in subdivision (b) is enabled to observe which MPN or MPNs are selected for the physician or group. If permitted by the written acknowledgment, the website listing may be amended without further action by the physician or the group, provided that the website enables the physician or the group to de-select any MPN. If the physician or group is removed from an MPN by anyone other than a person described in subdivision (b), the MPN applicant shall give the physician or group notice of that fact in writing or electronically.

(e) The acknowledgment shall be obtained at the time of the following occurrences:

(1) If, ~~on or after August 27, 2014,~~ the physician or medical group enters into a new contract or renews a contract to participate in the MPN, then the acknowledgment shall be obtained at the time of entering into or renewing the contract.

(2) If, ~~on or after August 27, 2014,~~ the physician joins a medical group that already has a contract to participate in an MPN or MPNs, the acknowledgment shall be obtained at the time of the physician's joining the medical group.

(3) ~~If, on or after January 1, 2014 but before August 27, 2014, the physician or medical group enters into a new contract or renews a contract to participate in the MPN, then the acknowledgment shall be obtained no later than January 1, 2015. Beginning June 1, 2026, the acknowledgement shall be obtained every four years unless the MPN can show that the physician has treated workers' compensation cases for that MPN in the four-year period and the physician has opted into the MPN, for example through a written acknowledgement or an MPN provider data base that complies with section (c).~~

(4) ~~If, on or after January 1, 2014 but before August 27, 2014, the physician joins a medical group that already has a contract to participate in an MPN or MPNs, the acknowledgment shall be obtained no later than January 1, 2015.~~

(5) ~~If a contract entered prior to August 27, 2014 is continuous or automatically renews without a new execution by or on behalf of the physician, then the acknowledgment shall be obtained no later than January 1, 2016, unless the MPN applicant can satisfy either (A) or (B) below:~~

(A) ~~The contract identifies the MPN in which the physician or group is participating.~~

(B) ~~A website address is openly published where a person described in subdivision (b) is enabled to observe which MPN or MPNs have been selected for the physician or group and to de-select any MPN. The means to authenticate a person to access the~~

~~website and to de-select any MPN shall be made available upon reasonable proof of the requesting person's identity as one of the persons authorized in subdivision (b).~~

(f) The MPN applicant shall retain a copy of the executed acknowledgment so long as it remains in force and for three years thereafter.

(g) The MPN applicant is responsible for obtaining physician acknowledgments and must ensure that all physician acknowledgments are up to date, meet regulatory requirements, and are readily available for review upon request by the Administrative Director.

Authority: Sections 133 and 4616, Labor Code. Reference: Section 4616(a), Labor Code, Section 16.5, Government Code, and Sections 1633.1 et seq. Civil Code.

### **Section 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 or claims administrator or entity that provides physician network services 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 or claims administrator 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 or claims administrator 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 an 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. If a chiropractor is selected as a treating physician, the chiropractor may act as a treating physician only until the 24-visit cap is met unless otherwise authorized by the employer or insurer or claims administrator, after which the covered employee must select another treating physician in the MPN who is not a chiropractor, and if the employee fails to do so, then the insurer or employer or claims administrator may assign another treating physician who is not a chiropractor.

(f) The insurer or employer shall deliver to the initial primary treating MPN physician selected by the employee, within twenty (20) days of notice of selected physician, all relevant medical records relating to the claim, if any, including the results of diagnostic and laboratory testing done in relation to the injured employee's treatment. The insurer or employer shall advise any subsequently selected MPN physician that any medical record or diagnostic and laboratory test result deemed relevant by that provider will be delivered upon request. The insurer or employer shall also advise all selected MPN physicians of the relevant MPN identification number, name, telephone number, fax number, email address, and mailing address of the person or entity to whom a request for authorization and bills should be sent.

(g) (f) A Petition for Change of Primary 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, except as allowed under subdivision (b)(6) of section 9786. If the employer petitions to change the Primary Treating Physician pursuant to Labor Code section 4603, the panel of physicians shall be from the current MPN provider listing and shall meet the applicable MPN Access Standards.

(h) If a workers' compensation judge or the Workers' Compensation Appeals Board determines that authorization for treatment with a MPN provider is unreasonably delayed, a penalty of \$1,000 shall be assessed. This penalty shall be treated as a separate species of penalty under Labor Code 5814(e) and may be appropriately assessed at trial, including Expedited Hearings pursuant to Labor Code 5502(b)(1). If a workers' compensation judge or the Workers' Compensation Appeals Board determines that authorization for treatment with a MPN provider is unreasonably delayed as a result of the MPN's failure to act an administrative penalty may issue in accordance with regulation section 9767.19(a)(1)(G) against the MPN. The workers' compensation judge or Workers' Compensation Appeals Board shall determine the cause of the delay and make and serve a specific finding on the Division of Workers Compensation at the time of decision finding an unreasonable delay.

Authority: Sections 133 and 4616(h), Labor Code.

Reference: Sections 4604.5, 4616, 4616.3, 5307.27 and 5401, Labor Code.

## **Section 9767.7. Second and Third Opinions.**

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(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 the primary treating physician or the treating physician, it is the employee's responsibility to: (1) inform the person designated by the employer or insurer or claims administrator 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 or claims administrator 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 or claims administrator of the appointment date. It is the employer's or insurer's or claims administrator's responsibility to (1) provide at least 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 within 5 business days of being informed of the appointment 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; and provide authorization for the evaluation. 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 or claims administrator and employee so the employer or insurer or claims administrator 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. The second opinion physician may charge for up to two hours of record review under the Official Medical Fee Schedule for this review and determination.

(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 or claims administrator 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 or claims administrator 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 or claims administrator of the appointment date. It is the employer's or insurer's or claims administrator's responsibility to (1) provide at least 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 within 5 business days of being informed of the appointment 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, and provide authorization for the evaluation. 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 or claims administrator 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. The third opinion physician may charge for up to two hours of record review under the Official Medical Fee Schedule for this review and determination.

(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 or claims administrator, 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 or claims administrator shall permit the employee to obtain the recommended treatment within the MPN or if the MPN does not contain a physician who can provide the recommended treatment, the employee may choose a physician outside the MPN within a reasonable geographic area. 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 MPN Independent Medical Review (MPN IMR), pursuant to Labor Code sections 4616.3, 4616.4 and title 8, California Code of Regulations sections 9768.1 et seq.

Authority: Sections 133 and 4616(h), Labor Code.

Reference: Sections 4616(a) and 4616.3, Labor Code.

### **Section 9767.8. Modification of Medical Provider Network Plan.**

(a) The MPN applicant shall serve the Administrative Director with ~~two copies~~ one copy of the completed, signed Notice of MPN Plan Modification and any necessary documentation ~~in~~ to an electronic address or by compact discs or flash drives in word-searchable PDF format. The hard copy of the original signed Notice of Medical Provider Network Plan Modification form and any necessary documentation shall be maintained by the MPN applicant and made available for review by the Administrative Director upon request. Electronic signatures ~~in compliance with California Government Code section 46.5~~ are accepted. The MPN applicant shall serve these documents with the Administrative Director within the stated time frames or if no time frame is stated, then before any of the following changes occur:

(1) Change in the name of the MPN or the name of the MPN applicant. Filing required within (15) fifteen business days of the change. Provide written documentation reflecting date of change.

(2) Change in the eligibility status of the MPN applicant. Filing required within fifteen (15) business days of written knowledge of a change in eligibility. Provide written documentation reflecting date of change.

(3) Change of ~~MPN Liaison or~~ Authorized Individual: Filing required within fifteen (15) business days of change. Provide written documentation reflecting date of change.

(4) Change in MPN geographic service area within the State of California.

(5) A material change in the continuity of care policy.

(6) A material change in the transfer of care policy.

(7) 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.

(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, a change in the Medical Access Assistants contact information, or a change in provider listing access or MPN 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) 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 current regulations pursuant to section 9767.15.

(b) Failure to file a material modification within the requisite time frame may result in administrative actions pursuant to sections 9767.14 and/or 9767.19.

(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 modification is true and correct.”

(d) A plan modification is not required if there is a change of MPN Liaison. Written notification of the change of MPN Liaison to the DWC is required within fifteen (15) business days of a change in the MPN Liaison. The fifteen days shall be from the date the prior identified MPN Liaison is no longer the MPN Liaison.

~~(d)~~(e) 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)(2), (a)(3) and (b) of this section, modifications shall not be made until the Administrative Director has approved the plan or until 60 days have passed, whichever 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)~~(f) 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)~~(g) 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)~~(h) 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 rescinding the Notice of Disapproval and issue an approval of the modification.

~~(h)~~(i) The Administrative Director may extend the time specified in subdivision (g) 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)~~(j) An 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 Appealing Administrative Director's Medical Provider Network Determination" with the Workers' Compensation Appeals Board pursuant to WCAB Rule

~~10959~~10580. A copy of the petition shall be concurrently served on the Administrative Director.

~~(j)~~(k) The MPN applicant shall use the following Notice of MPN Plan Modification form:

For DWC only: MPN Identification Number      Date Notice Received:    /    /

**Notice of Medical Provider Network Plan Modification §9767.8**

1. Legal Name of MPN Applicant \_\_\_\_\_

2. Name of MPN and MPN Identification Number \_\_\_\_\_

3. MPN Applicant Address      4. Tax Identification Number    --    --    --    --    --    --    --

\_\_\_\_\_

\_\_\_\_\_

5. Signature of authorized individual: "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 modification is true and correct."

\_\_\_\_\_  
Name of Authorized Individual      Title      Organization

\_\_\_\_\_  
Phone      Email

\_\_\_\_\_  
Signature of Authorized Individual      Date Signed

6. Authorized Liaison to DWC:

\_\_\_\_\_  
Name      Title      Organization

\_\_\_\_\_  
Phone      Email

\_\_\_\_\_  
Address      Fax number

7. Please give a short summary of the proposed modifications in the space provided below and place a check mark against the box that reflects the proposed modification.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

☐ Change of MPN name or MPN Applicant name: Provide new name and plan sections affected by the change within fifteen (15) business days of the change.

☐ Change in MPN Applicant eligibility status. Provide date of change in eligibility and reason for change. Must file within fifteen (15) business days of change in status.

☐ ~~Change of Division Liaison or Authorized Individual: Provide the name and contact information within fifteen (15) business days of change.~~

☐ Change in MPN Service Area: Provide documentation in compliance with section 9767.5.

☐ Change in continuity of care policy: Provide a copy of the revised written continuity of care policy.

☐ Change in transfer of care policy: Provide a copy of the revised written transfer of care policy.

☐ Change in Economic Profiling policy used by MPN Applicant or any entity contracted with MPN: Provide a copy of the revised policy or procedure.

☐ Change in how the MPN complies with the access standards: Explain what change has been made and describe how the MPN still complies with the access standards.

☐ Change in employee notification materials, including a change in MPN contact or Medical Access Assistants contact information, or a change in provider listing access or MPN website information: Provide a copy of the revised notification materials.

☐ 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.

Please state change: From \_\_\_\_\_ To \_\_\_\_\_

☐ Revision of any plan section(s) required by sections 9767.3(d)(8) or 9767.3(e) resulting from a change of any MPN administrator(s) listed in the MPN Plan. Please include complete sections revised.

☐ Replacement of entire plan application. Please state why and include entire revised plan.

☐ Update of MPN plan to the current regulations pursuant to section 9767.15. Please include entire updated plan.

Submit ~~two~~ one copy of the completed, signed Notice of MPN Plan Modification and any necessary documentation electronically to DWC Medical Unit or in compact discs or

flash drives in word-searchable PDF format to the Division of Workers' Compensation.  
Mailing address: DWC, MPN Application, P.O. Box 71010, Oakland, CA 94612.

[DWC Mandatory Form -- Section 9767.8 -- 5/14]

Authority: Sections 133, 4616(h) and 5300(f), Labor Code.

Reference: Sections 3700, 3743, 4616, 4616.2, and 4616.5, Labor Code.

### **Section 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, unless otherwise authorized by the employer or insurer or claims administrator.

(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, insurer, or entity that provides physician network services 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 or claims administrator 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 or claims administrator; and (B) to arrange for transfer to another provider within the MPN, as determined by the insurer, employer, or entity that provides physician network services. 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 or claims administrator decides to transfer the covered employee's medical care to the medical provider network, the employer, insurer, or entity that provides physician network services 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 address 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 or claims administrator referred to in (f) shall apply.

(h) If the employer or insurer or claims administrator 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 or claims administrator'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 or claims administrator'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.

(k) If there is a finding by a workers' compensation judge or the Workers' Compensation Appeals Board that there has been a denial of care and therefore the injured worker has been permitted to treat outside of the MPN the foregoing sections shall not be applicable.

Authority: Sections 133, 4616(h), and 4062, Labor Code.

Reference: Sections 4616 and 4616.2, Labor Code.

#### **Section 9767.10. Continuity of Care Policy.**

(a) At the request of a covered employee, an insurer, employer, or an entity that provides physician network services 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 or claims administrator's determination of the injured covered employee's medical condition, the employer, insurer, or an entity that provides physician network services 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

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sent to the covered employee's address 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 or claims administrator referred to in (d)(1) shall apply.

(3) If the employer or insurer or claims administrator 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 or claims administrator'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 or claims administrator'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.

Authority: Sections 133 and 4616(h), Labor Code.

Reference: Section 4616.2, Labor Code.

### **Section 9767.11. Economic Profiling Policy.**

a) An MPN applicant's filing of its economic profiling policies and procedures shall include:

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- (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.

Authority: Sections 133 and 4616(h), Labor Code.

Reference: Section 4616.1, Labor Code.

### **Section 9767.12. Employee Notification.**

(a) When an injury is reported or an employer has knowledge of an injury that is subject to an MPN or when an employee with an existing injury is required to transfer treatment to an MPN, a complete written MPN employee notification with the information specified in paragraph (2) of this subdivision, shall be provided to the covered employee by the employer or the insurer for the employer. This MPN notification shall be provided to employees in English and also in Spanish-if the employee primarily speaks Spanish.

(1) A complete MPN notification with the information specified in paragraph (2) of this subdivision may be sent electronically lieu of by mail, 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.

(2) The complete written MPN employee notification shall include the following information:

(A) The unique MPN Identification number. How to contact the person designated by MPN applicant to be the MPN Contact for covered employees to answer questions about the use of MPNs and to address MPN complaints. The employer or insurer or claims administrator shall provide a toll-free telephone number with access to the MPN Contact if the MPN geographic service area includes more than one area code. A toll-free number must also be listed for MPN Medical Access Assistants, with a description of the access assistance they provide, including finding available MPN physicians of the injured workers' choice and scheduling and confirming physician\_appointments, and the

times they are available to assist workers with obtaining access to medical treatment under the MPN;

(B) A description of MPN services as well as the MPN's web address for more information about the MPN including how to contact the MPN contact and medical access assistants and information about how to obtain a copy of MPN employee notification as required by regulation 9767.12 and the web address that includes a roster of all treating physicians and the complete statewide listing of all participating providers in the MPN;

(C) How to review, receive or access the MPN provider directory. An employer, insurer, or entity that provides physician network services 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 directory listing in writing and/or on the MPN's website. The MPN's website address shall be clearly listed. If an employee requests an electronic provider directory listing, it shall be provided electronically ~~on a CD, flash drive, via email or on a website. The URL address for the provider directory shall be listed with any additional information needed to access the directory online including any necessary instructions and passcodes. The MPN provider directory shall not be password protected.~~ MPN applicants are responsible for updating an MPN's provider listings, at minimum, on a quarterly basis with the date of the last update provided on the listing given to the employee. Each provider directory 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 directory within 45 days of notice to the MPN through the contact method stated on the provider directory listing to report inaccuracies. The MPN provider directory shall only list participating providers. The directory shall include, at a minimum, the name of each individual provider and their office address and office telephone number. If the ancillary service is provided by an entity rather than an individual, then that entity's name, address, and telephone number shall be listed. The MPN provider directory shall list out separately primary treating physicians by name and not by entity in a single searchable list by medical specialty and location.

(D) How to access initial care and subsequent medical care and how to contact the medical access assistants if an employee needs help in finding a physician or scheduling an appointment;

(E) The mileage, time requirements and alternative access standards required under section 9767.5;

(F) How to access treatment if (A) the employee is authorized by the employer to temporarily work or travel for work outside the MPN's geographic service area; (B) a former employee whose employer has ongoing workers' compensation obligations

permanently resides outside the MPN geographic service area; and (C) an injured employee decides to temporarily reside outside the MPN geographic service area during recovery;

(G) How to choose a physician within the MPN;

(H) What to do if a covered employee has trouble getting an appointment with a provider within the MPN and how to use the medical access assistants for help;

(I) How to change a physician within the MPN;

(J) How to obtain a referral to a specialist within the MPN or outside the MPN, if needed;

(K) How to use the second and third opinion process;

(L) How to request and receive an MPN independent medical review;

(M) A description of the standards for the transfer of care policy and a notification that a copy of the policy in English or in Spanish if the employee speaks Spanish shall be provided to an employee upon request; and

(N) A description of the standards for the continuity of care policy and a notification that a copy of the policy in English or in Spanish if the employee speaks Spanish shall be provided to an employee upon request.

(b) When MPN coverage will end, the employer or the insurer for the employer shall ensure each injured covered employee who is treating under its MPN is given written notice of the date the employee will no longer be able to use its MPN. The notice required by this section shall be provided in English and also in Spanish if the employee speaks Spanish.

(1) The employer or the insurer for the employer shall ensure that every affected injured covered employee using its MPN is provided the following information prior to the date its MPN coverage ends:

(A) The effective date the employee can no longer use the MPN. The unique MPN Identification number shall be stated in the notice.

(B) Whether the MPN will still be used for injuries arising before the date MPN coverage ends.

(C) The address(es), telephone number(s), and email address(es) of the MPN Contact and MPN Medical Access Assistants who can address MPN questions, and an MPN website.

(D) For periods when an employee 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.

(2) The following language may be provided in writing to injured covered employees to give the required notice of the end of coverage under an MPN: "The<Insert MPN Name>Medical Provider Network (MPN), under the unique MPN Identification number <Insert MPN-Identification number> will no longer be used for injuries arising after <Insert Date MPN Coverage Ends>. 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. For more information contact <Insert MPN Contact and Medical Access Assistants toll free number(s), MPN Address(es), MPN Email Address(es), and MPN Website."

(3) This required notice may be provided by mail or included on or with an employee's paystub, paycheck or sent electronically in lieu of mail, 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 MPN Independent Medical Review will end with the employee's coverage under the MPN.

(c) At the time of the selection of the physician for a third opinion, the covered employee shall be notified about the MPN Independent Medical Review process, as set forth in section 9768.9(a).

Authority: Sections 133 and 4616, Labor Code.

Reference: Sections 4616, 4616.2 and 4616.3, Labor Code.

### **Section 9767.13. Denial of Approval of Application or Reapproval; Re-Evaluation.**

(a) The Administrative Director shall deny approval or reapproval 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 corrected application or plan for reapproval 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 rescinding 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) An 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 Appealing Administrative Director's Medical Provider Network Determination" with the Workers' Compensation Appeals Board pursuant to WCAB Rule ~~10959~~10580. A copy of the petition shall be concurrently served on the Administrative Director.

Authority: Sections 133, 4616(h) and 5300(f), Labor Code.

Reference: Section 4616, Labor Code.

#### **Section 9767.14. Probation, Suspension or Revocation of Medical Provider Network Plan; Hearing.**



(a) The Administrative Director may place on probation, suspend or revoke a Medical Provider Network 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) The MPN fails to meet the requirements for reapproval under Labor Code section 4616 et seq. or this article.

(4) 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.

(5) 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.

(6) That an MPN failed to appeal an Administrative Director's Decision and Order assessing penalty and failed to pay said penalty within 90 days.

(7) That an MPN failed to timely file a plan modification as required by labor code section 4616 and regulation 9767.8.

~~(6)~~ (8) The MPN applicant no longer meets the eligibility requirements to have an MPN, including but not limited to the following situations: the MPN applicant is no longer recognized as a self-insured entity with the Office of Self-Insurance Plans for any period of time during which the MPN applicant has an MPN or if the MPN applicant is no longer properly licensed to provide workers' compensation insurance by the Department of Insurance for any period of time during which the MPN applicant has an MPN or is no longer an entity that provides physician network services.

(A) Once an MPN applicant is no longer eligible to have an MPN, by operation of law, the MPN is automatically suspended and MPN coverage will not be deemed valid for new claims during the period of suspension, pending revocation by the Administrative Director. During the effective dates of suspension, any injured worker with a new claim shall be informed of the employee's right to be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area 30 days after reporting the injury, pursuant to Labor Code section 4600(c). After a

suspension has ended, any transfer of the employee's care back into the MPN shall be subject to the MPN transfer of care requirements.

(9) If the MPN fails to submit a plan for reapproval six months prior to the expiration and the plan is not approved prior to the expiration the MPN shall be automatically suspended. MPN coverage will not be deemed valid for new claims during the period of suspension, pending revocation by the Administrative Director. During the effective dates of suspension, any injured worker with a new claim shall be informed within 30 days after reporting the injury of the employee's right to be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area, pursuant to Labor Code section 4600(c). After a suspension has ended, any transfer of the employee's care back into the MPN shall be subject to the MPN transfer of care requirements.

~~(7)~~(10) The MPN fails to respond to at least two or more repeated requests or inquiries by the Administrative Director to comply with the requirements of this article or Labor Code sections 4616 et seq.

(11) The MPN failed to provide Labor Code section 4609 notices to the participating provider in the MPN.

(b) If one of the circumstances in subdivision (a) exists, the Administrative Director shall notify the MPN applicant in writing of the specific violations alleged. The Administrative Director shall allow the MPN applicant an opportunity to correct the violation or to respond within ten days with a plan of action to correct the violation in a timely manner. If the Administrative Director determines that the violations have not been cured in a timely manner, he or she shall issue a Notice of Action to the MPN applicant that specifies the time period in which probation, the suspension or revocation will take effect and shall transmit the Notice of Action to the MPN applicant by U.S. Mail.

(c) An MPN applicant may request a re-evaluation of the probation, 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 rescinding 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) An 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 Appealing Administrative Director's Medical Provider Network Determination" with the Workers' Compensation Appeals Board pursuant to WCAB Rule ~~10959~~10580. A copy of the petition shall be concurrently served on the Administrative Director.

Authority: Sections 133, 4616(h) and 5300(f), Labor Code.

Reference: Section 4616, Labor Code.

### **Section 9767.15. Compliance with Current MPN Regulations; Reapproval.**

~~(a) MPNs approved prior to January 1, 2014 that are not in compliance with the current MPN regulations must file a modification and update to comply with the current regulations no later than January 1, 2018. If the MPN is required to apply for reapproval before January 1, 2018 based on the four-year approval period, then the MPN shall update to the current regulations with its reapproval filing, whichever is sooner.~~

~~(b)~~(a) The MPN applicant shall file a new complete application for reapproval no later than six months prior to the expiration of the MPN's four-year date of approval.

~~(1) For MPNs approved prior to January 1, 2014, the four-year date of approval begins from the most recent approved filing prior to January 1, 2014.~~

~~(2) For MPNs approved after January 1, 2014, the first four-year date of approval begins from the date the original application is approved.~~

~~(3)~~(1) After an MPN has been reapproved, the expiration of reapproval will be four years from the date of the last complete plan reapproval.

~~(4)~~(2) Each application for reapproval shall meet all requirements for a ~~new~~ MPN original application.

~~(5)~~(3) Each filing for reapproval shall meet the requirements for geocoding as follows: Provide an electronic copy in Microsoft Excel format of the geocoding results of the MPN provider directory to show estimated compliance with the access standards set forth in section 9767.5. The access standards set forth in section 9767.5 are determined by the injured employee's residence or workplace address and not the center of a zip code. The geocoding results will be used by DWC in reviewing MPN plans to give an approximation of MPN compliance with the access standards set forth in section 9767.5. The geocoding results shall include the following separate files summarizing data reasonably available at the time of compilation: 1) a complete list of all zip codes within the MPN geographic service area; 2) a narrative or graphic report that establishes where there are at least three available primary treating physicians within the fifteen-mile access standard from the center of each zip code within the MPN geographic service area; 3) a narrative or graphic report that establishes where there is a hospital or an emergency health care service provider within the fifteen-mile access standard from the center of each zip code within the MPN geographic service area; 4) a narrative or graphic report that establishes where there are at least three available physicians in each of the specialties commonly required to treat injured workers covered by the MPN within the thirty-mile access standard from the center of each zip code within the MPN geographic service area; 5) a list of all zip codes where access standards are not met in the geographic service area or areas to be served by the MPN for primary treating physicians, for acute care hospitals or emergency facilities, and for each specialty listed to treat common injuries experienced by injured workers covered by the MPN, and a narrative report explaining if medical treatment will be provided according to an approved alternative access standard or according to a written policy permitting out of MPN treatment in those areas; and 6) each physician listed in the MPN provider directory shall be assigned at least one provider code as set forth in section 9767.3(c)~~(2)~~ of this section to be used in the geocoding reports.

~~(6)~~(4) The time frames for the review process for a plan for reapproval are as stated in section 9767.2(b).

~~(7)~~(5) If the filing for reapproval is not filed within the requisite six months prior to the expiration of approval, then the MPN may be subject to penalties or other administrative actions. If an application for reapproval is filed less than 60 days prior to the approval expiration date, then the MPN may be subject to penalties and MPN ~~approval~~ will be suspended after the date of expiration if the review is not completed prior to the expiration of the MPN plan's approval.

Authority: Sections 133, 4616(h) and 5300(f), Labor Code.

Reference: Sections 4609, 4616, 4616.2 and 4616.3, Labor Code.

## **9767.16. Medical Provider Network Complaints.**

(a) Any person contending a Medical Provider Network is in violation of the requirements of this article or Labor Code sections 4616 through 4616.7 shall submit a written complaint directly with the MPN Contact.

(1) The written complaint shall provide an explanation to the MPN with sufficient detail of the MPN's alleged violation under this article or any of Labor Code sections 4616 through 4616.7. The written complaint shall include, but not be limited to, the following information:

(A) Citation of the specific statutory or regulatory provision(s) violated;

(B) When the alleged violation occurred;

(C) If the alleged violation is still occurring;

(D) What attempts the complainant has made with the MPN to address the violation;

(E) What, if any, impact there has been on an injured worker; and

(F) What remedy is sought for the alleged violation.

(2) The MPN applicant shall have thirty (30) calendar days from the date the complaint was received to respond in writing to the complainant.

(A) For purposes of this section, the complaint shall be deemed to have been received the next business day after the time of electronic submission. ~~For purposes of this section, the complaint shall be deemed to have been received by the MPN Contact by e-mail on the e-mail receipt confirmation date or on the delivery status notification date indicating successful delivery of an e-mail to the MPN Contact, whichever is earliest.~~

~~(B) Where the complaint is made by facsimile, the complaint shall be deemed to have been received by the MPN Contact on the date the receiving facsimile electronically date stamps the transmission was successfully sent. If there is no electronically stamped date recorded, then the date the request was transmitted.~~

~~(C)~~(B) Where the complaint is made by mail, and a proof of service by mail exists, the request shall be deemed to have been received by the MPN Contact five (5) days after the deposit in the mail at a facility regularly maintained by the United States Postal Service. Where the complaint is delivered via certified mail, return receipt mail, the request shall be deemed to have been received by the MPN Contact on the receipt date

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entered on the return receipt. In the absence of a proof of service by mail or a dated return receipt, the complaint shall be deemed to have been received by the MPN Contact on the date stamped as received on the document.

(3) Within (30) calendar days from the date the complaint was received, the MPN applicant shall respond to the complainant by:

(A) Taking reasonable actions to remedy the violation in a timely manner and stating any additional actions it will be taking if more than thirty (30) calendar days are needed to address the violation, or

(B) Verifying in writing to the complainant that the MPN is disputing the complaint and denying there is a violation.

(b) If the MPN applicant has not remedied the violation or has not taken reasonable action to remedy the violation within thirty (30) calendar days from the date the complaint was received or the MPN has confirmed in writing it is disputing the complaint and denying there is a violation, the complainant may file a written complaint with the Division of Workers' Compensation against the MPN. If the complainant can show imminent and serious threat to the health of an injured worker, including but not limited to potential loss of life, limb or other major bodily function, he or she may file a written complaint with the Division of Workers' Compensation against the MPN concurrently with the written complaint under subdivision (a) submitted on the MPN.

(1) The written complaint filed with the DWC must be made on the DWC Medical Provider Network Complaint Form, as contained in title 8, California Code of Regulations, section 9767.16.5. The complainant shall provide written details of the MPN's violation along with documentary evidence that the MPN has been notified according to subdivision (a) of this section. A copy of the DWC Medical Provider Network Complaint Form 9767.16.5 shall be served on the MPN Contact.

(2) The Administrative Director shall have the discretion to ~~limit investigations to~~ investigate complaints which provide credible evidence that a violation exists.

(A) The Administrative Director may make reasonable requests for information or documentary evidence from the MPN applicant or the complainant in order to conduct an investigation to determine the validity of the allegations. The MPN applicant or the complainant shall have thirty (30) calendar days from receipt of the Administrative Director's request, as determined by the parameters set forth in (a)(2)(A) through (C) of this section, to provide DWC with the requested information or documentary evidence.

(3) If the investigation confirms a violation or if other violations are found as a result of the investigation, the Administrative Director shall notify the MPN's authorized individual

and MPN Contact in writing of the specific violation(s) found and shall follow the procedures set forth in §9767.14 and/or §9767.19, if the MPN fails to remedy the violation as required.

Authority: 133, 4616, Labor Code.

Reference: Sections 4616(b)(4), and 4616(b)(5), Labor Code.

### **Section 9767.17. Petition for Suspension or Revocation of a Medical Provider Network.**

(a) The DWC Petition for Suspension or Revocation of a Medical Provider Network Form 9767.17.5, as contained in title 8, California Code of Regulations, section 9767.17.5, may be filed with the Division of Workers' Compensation by any person who can show:

(1) The employer, insurer or entity that provides physician network services failed to maintain its qualifying status to have an MPN, or

(3) That an MPN has systematically failed to meet access standards under 9767.5, at minimum, on more than one occasion in at least two specific access locations within the MPN geographic service area. Additionally, the MPN failed to ensure in each instance that a worker received necessary medical treatment within the MPN or failed to authorize treatment outside of the MPN within the required time frames and access standards.

(b) The failure of an MPN to accept or retain a particular provider in its network shall not be grounds to file a DWC Petition for Suspension or Revocation of a Medical Provider Network.

(c) The petitioner shall complete the DWC Petition for Suspension or Revocation of a Medical Provider Network Form 9767.17.5, include all supporting documentation and file the petition verified under penalty of perjury and with proof of service, directly with the Administrative Director. The petitioner shall concurrently serve a copy of the completed DWC Petition for Suspension or Revocation of a Medical Provider Network Form 9767.17.5 along with a copy of all supporting documentation on the MPN's authorized individual. The petition shall include details that show an MPN no longer meets the eligibility requirements to have a Medical Provider Network and/or an MPN systemically fails to meet the access standards. A petition for suspension or revocation of an MPN shall include but not be limited to the following:

(1) Documentation showing all attempts made to contact the MPN to address the violations that form the basis for the petition.

(2) Results of any and all attempts by petitioner to determine if the MPN has met the access standards on more than one occasion for the specific locations within the geographic service area or areas described in its plan.

(3) What, if any, impact the violation has had on injured workers.

(d) The MPN applicant has thirty (30) calendar days to respond to the petition after the date of service of the petition. The verified response shall include but not be limited to addressing the alleged violations and providing any supporting documentation to establish that no violation has occurred or that all specified violations have been remedied in a timely manner. Any response shall be served concurrently on the Administrative Director and on the petitioner.

(e) Within thirty (30) calendar days of the last day for the MPN applicant to file a response to the DWC Petition for Suspension or Revocation of a Medical Provider Network, the Administrative Director or his/her designee may make reasonable requests for information or additional evidence from the MPN or the petitioner.

(1) The MPN applicant or petitioner shall have thirty (30) calendar days from receipt of the Administrative Director's request, as determined by the parameters set forth in 9767.16(a)(2)(A) through (C), to provide DWC with the requested information or documentary evidence.

(f) Within sixty (60) calendar days of receipt of all the requested information or additional evidence, the Administrative Director shall issue an administrative Decision and Order either granting or denying the petition and setting forth the reasons for the Decision.

(g) Once the Administrative Director issues a Decision and Order, the procedures set forth in section 9767.14 and/or section 9767.19 may apply.

Authority: Sections 133 and 4616, Labor Code.

Reference: Section 4616(b)(5), Labor Code.

### **Section 9767.18. Random Reviews.**

(a) The Administrative Director may conduct random reviews of any approved Medical Provider Network to determine if the requirements of this article and Labor Code sections 4616 through 4616.7 are being satisfied.

(1) An MPN will not be randomly reviewed more than once in a two-year period. However, an MPN may be subject to investigation for good cause.



(2) To initiate a random review, the Division of Workers' Compensation shall:

(A) Issue a "Notice of Random Review" to a Medical Provider Network's authorized individual specifying the parameters of the review, including the time frame and scope of the review.

(B) Make reasonable requests in writing for information or documentary evidence from the MPN in order to conduct the review. MPN applicants shall be prepared to respond to reasonable requests for information or documentary evidence by the DWC including, but not limited to, the following items:

(i) Documentary proof the MPN applicant meets the eligibility requirements to have an MPN, that the MPN name or MPN applicant name is legally correct and consistent with the approved MPN plan, or that the MPN status is still valid and approved.

(ii) A complete copy of the MPN's most recent approved plan submission (new MPN application, reapproval plan or modification) including a copy of the most recent employee notification and MPN notices given to covered employees, and a listing of all plan filings to date after the effective date of this section.

(iii) A copy of the most recent network provider listing, the URL address of the MPN's network provider listing, documentary evidence of quarterly updates to the provider listing for the past year and documentary evidence of timely corrections to the provider listing for inaccuracies reported to the MPN within a reasonable time period.

(iv) A copy of any MPN complaints or petitions for suspension or revocation received by the MPN and the MPN's responses. In addition, documentation of any administrative actions taken by the Administrative Director against the MPN within a reasonable time period may be requested.

(v) A copy of the telephone call logs tracking the calls and the contents of the calls made to and by the MPN medical access assistants and the MPN Contact within a reasonable time period. Call logs shall consist of telephone calls made to and from the MAA or MPN contact or Adjuster if acting in the role of the MAA. Call logs shall include the date of the initial call, who called, the nature of the call, when the call was returned and how the matter was resolved. If the matter was addressed through electronic correspondence a log shall be kept of the correspondence in the same manner as the call log.

(vi) Copies of the written MPN physician acknowledgments.

(3) The MPN applicant shall have thirty (30) calendar days from receipt of the Administrative Director's request, as determined by the parameters set forth in 9767.16(a)(2)(A) through (C), to provide DWC with the requested information and or documentary evidence.

(4) If the review reveals that the MPN has violated or is in violation of a provision of this article or of Labor Code sections 4616 through 4616.7, the Administrative Director shall notify the MPN applicant in writing of the specific violation(s) found and may follow the procedures set forth in section 9767.14 and ~~or~~ section 9767.19.

Authority: Sections 122 and 4616(h), Labor Code.

Reference: Sections 4616(b)(4), 4616(b)(5), Labor Code.

### **Section 9767.19. Administrative Penalty Schedule; Hearing, Mitigation and Appeal.**

(a) A penalty may be assessed against an MPN applicant for each failure of an MPN to comply with the Medical Provider Network requirements in Labor Code sections 4616 through 4616.7 and Title 8, California Code of Regulations, sections 9767.1 et seq. For MPN applicants who have multiple MPNs and for multiple MPNs using the same network, if a specific violation affects more than one MPN, multiple penalties will not be assessed against the MPN applicant(s) provided that the violation is remedied for all affected MPNs within a reasonable time period, as determined by the Administrative Director based on the nature and extent of the violation. Penalties may be assessed against an MPN applicant for the following violations:

(1) MPN filing requirements with DWC:

(A) Failure to file a Notice of MPN Plan Modification within fifteen (15) business days of a change in the name of the MPN or the MPN applicant, \$500 initially and for each seven calendar days thereafter if the failure continues, up to \$5,000.

(B) Failure to file a Notice of MPN Plan Modification within fifteen (15) business days of a change in the MPN applicant's eligibility status, \$2,500.

(C) Failure to file a Notice of MPN Plan Modification within fifteen (15) business days of a change in ~~DWC liaison or~~ authorized individual, \$500 initially and for each seven calendar days thereafter if the failure continues, up to \$5,000.

(D) Failure to file a Notice of MPN Plan Modification for a material change in any of the employee notification materials, including but not limited to a change in MPN contact or

MPN medical access assistant information or a change in provider listing access or website information required by section 9767.12, \$2,500.

(E) Failure to file a Notice of MPN Plan Modification for all other material changes that require the filing of a Modification of MPN plan as set forth in section 9767.8, \$1,000.

(F) Failure to file a complete plan for MPN reapproval within the time frames set forth in section 9767.15, \$2,500.

(G) Failure to include geocoding of its current provider listing with the MPN reapproval application, \$500 for each 30 days or part thereof that the failure continues after the date of submission of the reapproval plan.

(H) Failure to provide written notification within fifteen (15) business days of a change in DWC liaison, \$500 initially and for each seven calendar days thereafter if the failure continues, up to \$5,000.

(I) Failure to provide Labor Code section 4609 notices to the participating provider in the medical provider network within thirty (30) days of the participating provider being listed in the network, \$500 penalty for each participating provider that did not receive the notice within the thirty (30) day period. The medical provider network shall have ninety (90) days from adoption of this regulation to provide all notices and thereafter the thirty (30) days shall apply from the participating provider being listed in the network.

(2) Network access requirements:

(A) Failure to perform the required quarterly provider listing updates pursuant to section 9767.12(a)(2)(C), for each inaccurate entry, \$250 up to a total of \$10,000 per quarter.

(B) Failure to update reported inaccuracies in the network provider online listing within forty-five (45) days of notice to the MPN through the contact method stated on the provider listings, \$250 for each occurrence up to a total of \$10,000, per quarter.

(C) Failure of an MPN medical access assistant to respond to calls by the next day, excluding Sunday and holidays, \$250 for each occurrence and \$50 for each additional day a response is not provided, up to a total of \$1,000 per occurrence.

(D) Failure of an MPN Applicant to permit an injured covered employee to obtain necessary non-emergency services for an initial MPN treatment from an out-of-network physician when the Medical Access Assistant fails to schedule an appointment within 3 business days of receipt of request from the injured covered employee, \$500 for each occurrence.

(E) Failure of an MPN Applicant to permit an injured covered employee to obtain necessary medical treatment from an appropriate out-of-network specialists requested by the primary treating physician when, within 10 business days of receipt of request from the injured covered employee, the MPN Medical Access Assistant has failed to schedule ~~or offer~~ an appointment with an appropriate specialist to occur within 20 days of the receipt of the request, \$500 for each occurrence.

(F) Failure to meet the physician acknowledgment requirements pursuant to section 9767.5.1; \$250 per non-compliant acknowledgment.

(G) A finding by a workers' compensation judge or the Workers' Compensation Appeals Board that authorization for treatment was unreasonably delayed due to the MPN error or mishandling, a penalty of \$1000 per occurrence.

(3) MPN cooperation with DWC's requests for information or documentary evidence:

(A) Failure to respond to a request for information or documentary evidence pursuant to an MPN complaint, petition for suspension or revocation of an MPN, random review or investigation, within thirty (30) calendar days of DWC's request, \$2,500.

(b) Penalties may be assessed against the employer or insurer or claims administrator responsible for these notices violations:

(1) Failure to provide the complete MPN employee notification pursuant to section 9767.12 to an injured covered employee, \$500 per occurrence up to \$10,000.

(2) Failure to provide the entire or correct complete MPN employee notification notice required under section 9767.12 to an injured covered employee, \$250 per occurrence up to \$10,000.

(3) Failure to provide an injured covered employee who is still treating under an MPN written notice of the date the employee will no longer be able to use the MPN, \$1,000 per occurrence.

(4) Failure to provide the MPN Independent Medical Review notice, \$250 per occurrence.

(5) Failure to provide the Transfer of Care notice to an injured covered employee, \$250 per occurrence up to \$10,000.

(6) Failure to provide the Continuity of Care notice to an injured covered employee, \$250 per occurrence up to \$10,000.

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(c) If a violation of any of the requirements of this article and or Labor Code section 4616 through 4616.7 is found, the Administrative Director shall notify the MPN applicant in writing of the specific violation. The Administrative Director shall allow the MPN applicant an opportunity to correct the violation or to respond within ten days with a plan of action to correct the violation in a timely manner. If the Administrative Director determines that the violation has not been cured in a timely manner, he or she shall issue a Notice of Action to the MPN applicant that specifies the time period in which the administrative penalty will take effect and shall transmit the Notice of Action to the MPN applicant by U.S. Mail.

(d) Penalty amounts may be mitigated upon written request to the Administrative Director by the MPN applicant within twenty-one days of the date of the Notice of Action. Mitigation will be determined based on the MPN's documented attempts to address the violation(s) of Labor Code sections 4616.1 through 4616.7 or of this article resulting in the penalties at issue, the responsiveness and good faith of the MPN in taking actions to prevent the violations from reoccurring, whether it is the first violation of its type, the frequency of violations found, the history of violations by the MPN, the medical harm or consequences of the violation(s) on an injured worker(s), and any extraordinary circumstances that may be relevant to mitigation of the penalties, when strict application of this mitigation provision would be clearly inequitable.

(e) An MPN applicant may request a re-evaluation of the administrative penalty, 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.

(f) 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 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 through 4616.7 and this article;

(2) Issue a Decision and Order rescinding the Notice of Action;

(g) The Administrative Director may extend the time specified in subdivision (f) 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.

(h) An 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 Appealing Administrative Director’s Medical Provider Network Determination” with the Workers’ Compensation Appeals Board pursuant to WCAB Rule 4095910580. A copy of the petition shall be concurrently served on the Administrative Director.

(i) If an MPN applicant does not appeal the Administrative Director’s Decision and Order and fails to pay the administrative penalty within 30 days but not to exceed 90 days the MPN shall be subject to suspension and/or revocation.

Authority: Sections 133 and 4616, Labor Code.

Reference: Section 4616(b)(4), 4616(b)(5), Labor Code.

## **Article 5.5.0 Rules for Medical Treatment Billing and Payment on or After October 15, 2011**

### **9792.5.16: Contract Agreements**

- a. A health care provider or health facility licensed pursuant to section 1250 of the Health and Safety Code may contract with a contracting agent, employer, or carrier for reimbursement rates different from those in the fee schedule pursuant to Labor Code section 5307.1.
- b. “Contracting Agent” is a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, a disability insurer licensed by the California Department of Insurance, a third-party administrator with a certificate to administer by the California Department of Insurance, a health care service plan, including a specialized health care service plan, a preferred provider organization as defined in title 5 California Code of regulations section 4610, a self-insured employer approved by the Office of Self-Insured Plans (OSIP), an approved health care organization certified in accordance with Labor Code section 4600.5 and a medical provider network approved by the Administrative Director in accordance with Labor Code section 4616.
- c. The contracted reimbursement rates must be established through an express written and executed agreement. All terms regarding pricing and reimbursement rates must be explicitly stated in the contract. The health care provider or health facility licensed pursuant to section 1250 and the contracting agent, employer, or carrier must be parties to the contract for the reimbursement rate to apply. Implied or verbal agreements regarding pricing are not a basis for a reduction in payment.

- d. All contracts under which a reimbursement rate is claimed must provide a complete list of the contracting agent, employer, or carrier in which the health care provider or health facility licensed pursuant to section 1250 agrees to accept that rate. The rate under the contract shall not apply if the specific contracting agent, employer, or carrier is not expressed in the contract.
- e. The contract cannot require a health care provider or health facility licensed pursuant to section 1250 to accept virtual credit card payments. Health care providers or health facilities licensed pursuant to section 1250 of the Health and Safety Code have the right to refuse virtual credit card payments and to specify their preferred method of payment within the contract.
- f. If there is a dispute regarding the contracting rate versus the official medical fee schedule rate under labor code section 5307.1, the dispute shall be resolved in accordance with Labor Code section 4603.6.

Authority: Sections 133 and 5307.3, Labor Code

Reference: Section 5307.11, 4603.6, 4616, Labor Code