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 interpreter services, physical therapy and pharmaceutical services.

~~(2) "Cessation of use" means the discontinued use of an implemented MPN that continues to do business.~~

(~~3~~2) "Covered employee" means an employee or former employee whose employer has ongoing workers' compensation obligations and whose employer or employer's insurer ~~has established~~ 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 and/or 3201.81.

(43) "Division" means the Division of Workers' Compensation.

(~~5~~4) "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.

(~~6~~5) "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.

(~~7~~6) "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) "Entity that provides physician network services" means a legal entity employing or contracting with physicians and other medical providers 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) "Geocoding" means the mapping of addresses within specific geographic location(s) or coordinate space.

(~~8~~9) "Group Disability Insurance Policy" means an entity designated pursuant to Labor Code section 4616.7(c).

(~~9~~10) "Health Care Organization" means an entity designated pursuant to Labor Code section 4616.7(a).

(~~10~~11) "Health Care Service Plan" means an entity designated pursuant to Labor Code section 4616.7(b).

(12) "Health care shortage" means a situation in either a rural or non-rural area in which there is an insufficient number of physicians in a particular specialty 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. An insufficient number of physicians is not established when there are non-MPN physicians in that specialty available within the access standards.

(~~11~~13) "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.

(~~12~~14) "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) "Medical Provider Network Approval Number" means the unique number assigned by DWC to a Medical Provider Network upon approval and used to identify each approved Medical Provider Network.

(16) "Medical Provider Network Medical Access Assistant" means an individual in the United States whose duties include providing assistance to injured workers to obtain medical treatment under a Medical Provider Network, including but not limited to assistance with finding available Medical Provider Network providers and assistance with scheduling Medical Provider Network provider appointments.

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

(~~13~~18) "Medical Provider Network Plan" means an employer's, ~~or~~ insurer's, or entity that provides physician network services' detailed description for a ~~m~~Medical ~~p~~Provider ~~n~~Network

contained in a~~n~~ complete application submitted to the Administrative Director by an MPN a~~A~~pplicant.

(~~14~~19) "MPN Applicant" means an insurer or employer as defined in subdivisions (6) and (~~11~~13) of this section, or an entity that provides physician network services as defined in subdivision (7).

(~~15~~20) "MPN Contact" means an individual(s) designated by the MPN Applicant in the employee notification who is responsible for responding to complaints, answering employees' questions about the Medical Provider Network and ~~is responsible~~ for assisting the employee in arranging for an MPN independent medical review.

~~(16) "Nonoccupational Medicine" means the diagnosis or treatment of any injury or disease not arising out of and in the course of employment.~~

(~~17~~21) "Occupational Medicine" means the diagnosis or treatment of any injury or disease arising out of and in the course of employment.

~~(18) "Physician primarily engaged in treatment of nonoccupational injuries" means a provider who spends more than 50 percent of his/her practice time providing non-occupational medical services.~~

(~~19~~22) "Primary treating physician" means a primary treating physician within the medical provider network and as defined by section 9785(a)(1).

(23) "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.*

(~~20~~24) "Provider" means a physician as described in Labor Code section 3209.3 or other ~~provider~~ practitioner as described in Labor Code section 3209.5.

(~~21~~25) "Regional area listing" means either:

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

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

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

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

(~~22~~26) "Residence" means the covered employee's primary residence.

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

(~~23~~28) "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.

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

(~~24~~30) "Taft-Hartley health and welfare fund" means an entity designated pursuant to Labor Code section 4616.7(d).

(~~25~~31) "Termination" means the permanent discontinued use of an implemented MPN that ceases to do business.

(~~26~~32) "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.

(~~27~~33) "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) "Withdrawal" means the permanent discontinuance of an approved MPN that was never implemented.

(~~28~~35) "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, 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 Application for Reapproval

(a) Within 60 days of the Administrative Director's receipt of a complete application, the Administrative Director shall approve for a four-year period or disapprove an 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 plan within 60 days of submittal of a complete plan, it shall be deemed approved on the 61st day for a period of four years.

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

(c) 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 (b).

(d) The Administrative Director's decision to approve or disapprove an application shall be limited to his/her review of the information provided in the application.

(e) Upon approval of the Medical Provider Network Plan, the MPN ~~applicant~~ shall be assigned a MPN approval number. At minimum, this unique approval number is to be used in all correspondence with DWC regarding the MPN, including but not limited to future filings and complaints.

(f) 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, a statement verifying that that MPN has never been used and that the MPN applicant does not wish to use the MPN in the future.

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

Reference: Section 4616, Labor Code.

Section 9767.3 Application 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 plans in its application.

(b) Nothing in this section precludes an ~~insurer and an insured employer~~ 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 ~~submit an original~~ complete the section 9767.4 Cover Page for Medical Provider Network Application or Application for Reapproval with an original signature, ~~an original application, and a copy of the Cover Page for Medical Provider Network and application to the Division~~ and an MPN Plan application meeting the requirements of this section or the optional MPN Application form. The completed application documents and a copy of the completed documents shall be submitted in word-searchable PDF format on a computer disk, CD ROM, or flash drive with an original signature on the Cover Page for Medical Provider Network Application or Application for Reapproval. Valid electronic signatures are accepted. The hard copy of the original signed cover page shall be maintained by the MPN applicant and made available for review by the Administrative Director upon request.

(1) An MPN applicant shall submit the MPN provider information and/or ancillary service provider information required in section 9767.3(d)(8)(C) and (D) on a computer disk(s) or CD ROM(s). 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 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) ~~If t~~The network provider information ~~is~~ shall be submitted on a disk(s), ~~or~~ CD ROM(s), or a flash drive, and the provider file ~~must~~ shall have only the following ~~three~~ six columns. These columns shall be in the following order: (1) physician name (2) specialty ~~and~~ (3) physical address ~~location~~ (4) city (5) state (6) zip code of each physician listing. By submission of its provider listing, the ~~A~~applicant is affirming that all of the physicians listed ~~have~~ understand 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.

(3) The ancillary service provider file ~~must~~ shall have only the following ~~three~~ six columns. The columns shall be in the following order: (1) the name of the each ancillary service provider (2) specialty or type of service ~~and~~ (3) ~~location~~ physical address (4) city (5) state (6) zip code of each ancillary service provider. If the ancillary service or ancillary service provider is mobile, list the covered service area by zip code(s) within California. By submission of an ancillary provider listing, the ~~A~~applicant is affirming that the providers listed can provide reasonable and necessary medical services and have a current valid license number to practice, if they are required to have a license by the State of California.

(4) If an MPN lists a medical group in its provider listing, then all physicians in that medical group are considered to be approved providers. An MPN may list a subgroup of a larger medical group if all physicians in the larger group are not in the MPN, or an MPN may list approved providers individually.

(5) An MPN determines which locations are approved for providing treatment under the MPN, which are listed in its provider listing. An MPN has the discretion to approve treatment at non-listed locations.

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

(d) ~~If the network is not a Health Care Organization, Health Care Service Plan, Group Disability Insurance Policy, or Taft-Hartley Health and Welfare Fund, a~~ A Medical Provider Network application shall include all of the following information:

(1) Type of Eligible MPN ~~A~~applicant~~: Insurer or Employer.~~ If a self-insured employer or joint powers authority, attach a copy of the current valid certificate of self-insurance. For an insurer, attach current valid certificate(s) of insurance. For an entity providing physician network services, please attach documentation of current legal status including, but not limited to, legal licenses or certificates.

(2) Name of MPN ~~A~~applicant.

(3) MPN ~~A~~applicant's Taxpayer Identification Number.

(4) Name of Medical Provider Network~~, if applicable.~~ Use a name that is not used by an existing approved Medical Provider Network.

(5) ~~Division~~ 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 ~~insurer or employer.~~ eligible MPN applicant.

(8) Description of Medical Provider Network Plan:

(A) State the number of employees expected to be covered by the MPN plan and the method used to calculate the number;

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

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

(D) The MPN website address;

(E) The web address or URL to the MPN provider listing;

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

(~~C~~G) A listing of ~~T~~the name, specialty, and location of each physician as described in Labor Code Section 3209.3~~, or other providers as described in Labor Code Section 3209.5~~, who will be providing occupational medicine services under the plan. 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 of the geocoded provider listing to show compliance with the access standards for the injured workers being covered by the MPN. This geocoded listing must be provided in electronic format created with geocoding software. The geocoding shall include mapping of the provider locations by street address or zip code within the applicable access standards for the entire MPN geographic service area and be mapped on separate maps by specialty.

(~~D~~I) A voluntary listing of ~~T~~the name, specialty or type of service and location of each ancillary service, other than a physician ~~or provider~~ covered under subdivision (d)(8)(~~C~~G) of this section, who will be providing medical services 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;

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

~~(F) Describe how the MPN complies with the goal of at least 25% of physicians (not including pediatricians, OB/GYNs, or other specialties not likely to routinely provide care for common injuries and illnesses expected to be encountered in the MPN) primarily engaged in the treatment of nonoccupational injuries;~~

(~~G~~J) Describe how the MPN arranges for providing ancillary services to its covered employees. Set forth which ancillary services, if any, will be within the MPN. For ancillary services not within the MPN, affirm that referrals will be made to services outside the MPN;

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

(~~H~~L) Describe how the MPN complies with the access standards set forth in section 9767.5 for all covered employees. In addition, from the following list, state the five most commonly used specialties based on the common injuries for workers covered under the MPN: orthopedic medicine, chiropractic medicine, occupational medicine, acupuncture medicine, psychology, pain specialty medicine, occupational therapy medicine, psychiatry, neurosurgery, family medicine, neurology, internal medicine, physical medicine and rehabilitation, or podiatry. If there is a specialty not listed in this subsection that is used to treat common injuries of covered injured workers under the MPN, please state the specialty and explain how it is one of the five most commonly used specialties for the workers covered under the MPN;

(~~I~~M) Describe the employee notification process, and attach an English and Spanish ~~sample~~ copy of the required employee notification material and information to be given to covered employees described in section 9767.12~~(d)~~(a). ~~and (g). Any specific MPN contact or provider listing access information that is not available for administrative review in the sample employee notification shall be included in the MPN employee notification distributed to employees;~~

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

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

(~~L~~P) 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;

(~~M~~Q) 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

(~~N~~R) 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) Describe the MPN's procedures used to ensure ongoing quality of care and how performance of medical personnel, utilization of services and facilities, and costs provided by the MPN are sufficient to provide adequate and necessary medical treatment for covered employees.

(T) 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 another contracting agent shall,

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.

~~(c) If the entity is a Health Care Organization, a Medical Provider Network application shall set forth the following:~~

~~(1) Type of MPN Applicant: Insurer or Employer~~

~~(2) Name of MPN Applicant~~

~~(3) MPN Applicant's Taxpayer Identification Number~~

~~(4) Name of Medical Provider Network, if applicable.~~

~~(5) Division Liaison: 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 insurer or employer.~~

~~(8) Describe how the MPN complies with the second and third opinion process set forth in section 9767.7;~~

~~(9) Confirm that the application shall set forth that at least 25% of the network physicians are primarily engaged in nonoccupational medicine;~~

~~(10) Describe the geographic service area or areas within the State of California to be served and affirm that this access plan complies with the access standards set forth in section 9767.5;~~

~~(11) Describe the employee notification process, and attach an English and Spanish sample of the employee notification material described in sections 9767.12(d) and (g). Any specific MPN contact or provider listing access information that is not available for administrative review in the sample employee notification shall be included in the MPN employee notification distributed to employees;~~

~~(12) Attach a copy of the written continuity of care policy as described in Labor Code section 4616.2;~~

~~(13) Attach a copy of the written transfer of care policy that complies with section 9767.9 with regard to the transfer of on-going cases from the HCO to the MPN;~~

~~(14) Attach a copy of the 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; and~~

~~(15) Describe the number of employees expected to be covered by the MPN plan and confirm that the number of employees is within the approved capacity of the HCO.~~

~~(16) 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 with the providers is in compliance with Labor Code section 4609, if applicable.~~

(~~f~~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 (~~e~~d) [excluding ~~(e)(9)~~ (d)(8)(G), (d)(8)(H) and ~~(e)(15)~~ (d)(8)(I)] 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.

(~~g~~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.

(~~h~~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).

(~~i~~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.

Section 9767.4: Cover Page for Medical Provider Network Application or Application for Reapproval

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

Cover Page for Medical Provider Network Application or Application for Reapproval

1. Legal Name of MPN Applicant_____

2. MPN Applicant Address

_____

_____

3. Tax Identification Number __ __ -- __ __ __ __ __ __ __

4.~~Type of~~ Eligibility Status of MPN Applicant

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

5. Name of Medical Provider Network~~(s), if applicable:~~_____

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. Name of entity, administrator or other third-party who prepared MPN Application on behalf of MPN aApplicant (if applicable): _____~~

7. Is this an application for reapproval? □ Yes □ No If Yes, include date of last MPN approval:
_____

8. MPN Website Address: _____

9. MPN Provider Listing Web Address: _____

~~8.~~ 10. 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 ~~ability~~belief, the information included in this application is true and correct."

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

~~9.~~ 11. Authorized Liaison to DWC:

Name	Title	Organization	~~Phone/Email~~
Phone	Email		
Address			Fax number

Submit an original Cover Page for Medical Provider Network Application with original signature, a complete application and copy of the complete application and cover page in word-searchable PDF format on a computer disk, CD ROM, or flash drive to the Division of Workers' Compensation. Mailing address: DWC, MPN Application, P.O. Box 71010, Oakland, CA 94142.

[DWC Mandatory Form - Section 9767.4 - ~~09/15/05~~[08/13]

Section 9767.5. Access Standards

(a) A MPN must have at least three available physicians of each specialty ~~expected~~ 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 (b) and (c). An MPN shall meet the access standards for the five commonly used specialties listed in its application at all times.

(b) A MPN must have a primary treating physician 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.

(c) A MPN must have providers of occupational health services and specialists within 60 minutes or 30 miles of a covered employee's residence or workplace.

(d) 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, such as rural areas

including those in which health facilities are located at least 30 miles apart, the accessibility standards set forth in subdivisions (b) and/or (c) are unreasonably restrictive, 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 ~~approval~~ application or in a notice of MPN plan modification for approval. The applicant shall explain how the proposed alternative mileage standard was determined to be necessary for the specialty(ies) in which there is a health care shortage. The alternative standards shall provide that all services shall be available and accessible at reasonable times to all covered employees.

(e)(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 ~~the choice of~~ 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 paragraphs (c) and (d) of this section.

(4) Nothing in this section precludes ~~a MPN applicant from having a written policy that allows a~~ covered employee outside the MPN geographic service area from ~~to~~ chooseing his or her own provider for non-emergency medical care.

(f) For non-emergency services, the MPN applicant shall ensure that an appointment for initial treatment is available within 3 business days of the MPN applicant's receipt of a request for treatment within the MPN.

(g) 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 appointment is available within 20 business days of the MPN applicant's receipt of a referral to a specialist within the MPN.

(h) MPN access assistants shall be located in the United States and available to provide in English or Spanish employee assistance with access to medical care under the MPN, including but not limited to contacting provider offices during regular business hours and scheduling medical appointments, at a minimum from Monday through Saturday, from 7 am to 8 pm, Pacific Standard Time.

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

(2) The MPN access assistants shall also 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.

(~~h~~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.

(~~i~~j) 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) Each physician, as defined in Labor Code section 3209.3, in an MPN shall have a written acknowledgment to participate in that MPN unless the physician is a shareholder, partner or employee of a medical group that elects to be part of an MPN.

(b) If a physician has a contract that automatically renews, then a physician must submit a written acknowledgment with an original signature by the physician or his/her legal agent/designee no later than the contract renewal date that clearly specifies the time frame of the acknowledgment. Valid electronic signatures are acceptable.

(c) A physician may acknowledge participation in multiple MPNs in a single written acknowledgment signed with an original signature by the physician or his/her legal agent/designee.

(d) A single written group acknowledgment may be submitted for a medical group on behalf of all members of the medical group if each physician signs the acknowledgment with an original signature by the physician or his/her legal agent/designee. If at any point a signatory to the group acknowledgment is no longer participating in the MPN or if new members join the medical group, then an amendment to the original group acknowledgment shall be submitted to the MPN. The amendment shall include a statement that a physician is no longer participating in the MPN or medical group and/or the signature of the physician who is joining the medical group and MPN. This amendment shall be submitted to the MPN within ten days of the effective date of the change.

(e) The MPN applicant must ensure that all physician acknowledgments are readily available for review upon request by the Administrative Director.

Authority: Sections 133 and 4616, Labor Code.

Reference: Sections 4616(a), Labor 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 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 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 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 or entity that provides physician network services 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 a 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, after which the covered employee must select another treating physician in the MPN who is not a chiropractor.

(f) A Petition for Change of 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.

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

(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 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 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 of the appointment date. It is the employer's or insurer'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 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. 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 and employee so the employer or insurer 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.

(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 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 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 of the appointment date. It is the employer's or insurer'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 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. 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 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.

(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, 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 shall permit the employee to obtain the recommended treatment within or outside the MPN. 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, 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 an original Notice of MPN Plan Modification with original signature, any necessary documentation, and a copy of the Notice and any necessary documentation 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.

(2) Change in the eligibility status of the MPN Applicant. Filing required within five (5) business days of knowledge of a change in eligibility.

(3) Change of Division Liaison or Authorized Individual: Filing required within fifteen (15) business days of change.

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

(~~1~~5) A change of 10% or more in the number or specialty of providers participating in the network since the approval date of the previous MPN Plan application or modification.

(~~2~~6) A change of 25% or more in the number of covered employees since the approval date of the previous MPN Plan application or modification.

(~~3~~7) A material change in the continuity of care policy.

(~~4~~8) A material change in the transfer of care policy.

(~~5~~9) 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.

~~(6) Change in the name of the MPN or the MPN Applicant.~~

~~(7) Change in geographic service area within the State of California.~~

(~~8~~10) Change in how the MPN complies with the access standards.

(~~9~~11) A material change in any of the employee notification materials, including a change in MPN contact or Medical Access Assistants information or a change in provider listing access or MPN website information, required by section 9767.12.

(~~10~~12) 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~~13) Revision of any plan section(s) required by sections 9767.3(d)~~(8) or 9767.3(e)~~ due to a change of any MPN administrator(s) listed in the MPN Plan.

(~~12~~14) Replacement of entire MPN plan application.

(~~13~~15) Updating to the ~~permanent~~ current regulations pursuant to section 9767.15.

(b) The MPN applicant shall serve the Administrative Director with a Notice of MPN Plan Modification within fifteen (15) business days of a change of the DWC liaison~~,~~ ~~or~~ authorized individual~~.~~, MPN name or MPN applicant name, and within five (5) business days of a change in

eligibility status of the MPN applicant. Failure to file the updated information 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 ~~notice~~ modification is true and correct."

(d) 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)(~~6~~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, which ever 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) 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) 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) 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 ~~revoking~~ rescinding the Notice of Disapproval and issue an approval of the modification.

(h) The Administrative Director may extend the time specified in subdivision (~~h~~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) 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 ~~p~~ "Petition Appealing Administrative Director's Medical Provider Network Determination" with the Workers' Compensation Appeals Board pursuant to WCAB Rule 10959. ~~at the district office of the Workers' Compensation Appeals Board closest to the MPN applicant's principal place of business, together with a Declaration of Readiness to Proceed. The petition shall set forth the specific factual and/or legal reason(s) for the appeal.~~ A copy of the petition ~~and of the Declaration of Readiness to Proceed~~ shall be concurrently served on the Administrative Director.

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

For DWC only: MPN Approval 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 Approval Number: _____

~~2~~3. MPN Applicant Address ~~3.~~ 4. Tax Identification Number __ __ -- __ __ __ __ __ __

_____

_____

~~4.~~5. Type of MPN Applicant_____

☐ Self-Insured Employer ☐ Insurer ☐ Group of Self-Insured Employers

~~☐ Self-Insured Security Fund~~ ☐ Joint Powers Authority ☐ State ~~☐ Insurer~~

☐ Entity that provides physician network services

~~5. Name of MPN, if applicable:~~

~~6. Date of initial application approval and MPN approval number:~~
~~_____~~

~~7.~~6. Date~~s~~ of last ~~prior~~ plan modifications approval~~s~~:
_____

~~8. 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~~

~~9. Name of entity, administrator or other third-party who prepared MPN Application on behalf of MPN applicant (if applicable): _____~~

~~10~~ 7. 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 ~~ability~~belief, the information included in this ~~application~~ modification is true and correct."

Name of Authorized Individual Title Organization ~~Phone/Email~~

Phone Email

Signature of Authorized Individual Date Signed

~~11.~~ 8. Authorized Liaison to DWC:

Name Title Organization ~~Phone/Email~~

Phone Email

Address Fax number

9. 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. ~~Please explain whether the modification will adversely affect the ability of the MPN to meet the regulatory and statutory MPN requirements.~~

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

☐ 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 five (5) 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 of 10% or more in the number or specialty of Network Providers since the approval date of the previous MPN Plan application or modification: Provide the name, and location of each physician by specialty type or name provider, if other than physician.

☐ Change of 25% or more in the number of covered employees since the approval date of the previous MPN Plan application or modification.

☐ 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 of employee notification materials, including a change in MPN contact or Medical Access Assistants 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 ~~permanent~~ current regulations pursuant to section 9767.15. Please include entire updated plan.

Submit an original Notice of MPN Plan Modification with original signature, any necessary documentation, and a copy of the Notice and documents in word-searchable PDF format on a computer disk, CD ROM, or flash drive to the Division of Workers' Compensation. Mailing address: DWC, MPN Application, P.O. Box 71010, Oakland, CA 94612.

[DWC Mandatory Form -- Section 9767.8 -- ~~June 2010~~ 08/13]

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.

(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, ~~or~~ 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 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; and (B) to arrange for transfer to another provider within the MPN, as determined by the insurer, ~~or~~ 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 decides to transfer the covered employee's medical care to the medical provider network, the employer, ~~or~~ 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 residence 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 referred to in (f) shall apply.

(h) If the employer or insurer 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 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 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.

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, ~~or~~ 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 determination of the injured covered employee's medical condition, the employer, ~~or~~ 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 sent to the covered employee's residence 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 referred to in (d)(1) shall apply.

(3) If the employer or insurer 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 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 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 ~~insurer's or employer's~~ MPN applicant's filing of its economic profiling policies and procedures shall include:

(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) ~~An employer or insurer that offers a Medical Provider Network Plan under this article shall notify every covered employee in writing about the use of the Medical Provider Network prior to the implementation of an approved MPN. An implementation notice shall also be provided to a new employee at the time of hire. An implementation notice is not required if the MPN Applicant or insured employer is changing from one MPN to another MPN within 60 days. The MPN implementation notice shall be provided in English and also in Spanish, to Spanish-speaking employees. The written MPN implementation notice to all covered employees shall, at a minimum, include the following information:~~

~~(1) That medical treatment for new work injuries will be provided through the Medical Provider Network as of the effective date of coverage unless the employee properly predesignates a physician or medical group prior to injury;~~

~~(2) The effective date of coverage under the new MPN;~~

~~(3) That existing work injuries may be transferred into the new MPN. The worker should check with the worker's claims adjuster for more information;~~

~~(4) That more information about the MPN can be found on the workers' compensation poster or by asking your employer.~~

~~(b) The following language may be used for the written MPN implementation notice provided to covered employees: "Unless you predesignate a physician or medical group, your new work injuries arising on or after <INSERT EFFECTIVE DATE OF NEW MPN> will be treated by providers in a new Medical Provider Network, <INSERT NEW MPN NAME>. If you have an existing injury, you may be required to change to a provider in the new MPN. Check with your~~

~~claims adjuster. You may obtain more information about the MPN from the workers'compensation poster or from your employer."~~

~~(c) The MPN implementation notice may be provided by mail or included on or with an employee's paystub, paycheck or distributed through electronic means, including email, if the employee has regular electronic access to email at work to receive this notice prior to the implementation of the MPN. 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 implementation of the MPN.~~

~~(d)~~ ~~Separate from the MPN implementation notice,~~ At the time of injury 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 ~~subdivision (f)~~ paragraph (2) of this ~~section about coverage under the MPN~~ subdivision, shall be provided to the covered employee~~s~~ by the employer, insurer or entity that provides physician network services. ~~at the time of injury or when an employee with an existing injury begins treatment under the MPN.~~ This MPN notification shall be provided to employees in English and also in Spanish ~~to Spanish speaking employees~~if the employee primarily speaks Spanish. ~~Before MPN coverage is implemented, the complete written MPN employee notification shall also be posted in both English and Spanish in a conspicuous location frequented by employees during the hours of the workday and in close proximity to the workers' compensation posting required under section 9881.~~

(~~e~~1) ~~The~~ A complete MPN notification with the information specified in paragraph (2) of this subdivision may be ~~distributed through~~ sent electronically ~~means, including email~~in 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.

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

(~~1~~A) How to contact the person designated by ~~the employer or insurer~~ MPN applicant to be the MPN Contact for covered employees to answer questions about the use of MPNs and to address MPN ~~problems~~complaints. The employer or insurer shall provide a toll-free telephone number with access to the MPN Contact if the MPN geographic~~al~~ 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 can provide and the times they are available to assist workers with obtaining access to medical treatment under the MPN;

(~~2~~B) A description of MPN services and the MPN's approval number;

(~~3~~C) How to review, receive or access the MPN provider directory. An employer, ~~or~~ 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 listing in writing and on the MPN's website. The MPN's website

address shall be clearly listed. If an employee requests an electronic listing, it shall be provided electronically on a CD or on a website. ~~If the provider directory is also accessible on a website, t~~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. ~~All provider listings shall be regularly updated~~ MPN applicants are responsible for updating and for confirming the accuracy of 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~~, to ensure the listing is kept accurate~~. Each provider 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 list within ~~60~~ 30 days of notice to the MPN through the contact method stated on the provider listing to report inaccuracies ~~network administrator~~.

(4D) 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;

(~~5~~E) The mileage, time requirements and alternative access standards required under section 9767.5;

(~~6~~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~~al~~ service area; (B) a former employee whose employer has ongoing workers' compensation obligations permanently resides outside the MPN geographic~~al~~ service area; and (C) an injured employee decides to temporarily reside outside the MPN geographic service area during recovery;

(~~7~~G) How to choose a physician within the MPN;

(~~8~~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;

(~~9~~I) How to change a physician within the MPN;

(~~10~~J) How to obtain a referral to a specialist within the MPN or outside the MPN, if needed;

(~~11~~K) How to use the second and third opinion process;

(~~12~~L) How to request and receive an MPN independent medical review;

(~~13~~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

(~~14~~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 MPN applicant 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 MPN Applicant 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 specific MPN name and MPN approval 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 MPN approval number <Insert MPN approval 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 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.

(~~g~~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). ~~The notification shall be written in English and also in Spanish to Spanish speaking employees.~~

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 ~~and~~ 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 ~~new~~ corrected application 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 ~~revoking~~ 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 ~~p~~ "Petition Appealing Administrative Director's Medical Provider Network Determination" with the Workers' Compensation Appeals Board pursuant to WCAB Rule 10959. ~~at the district office of the Workers' Compensation Appeals Board closest to the MPN applicant's principal place of business, together with a Declaration of Readiness to Proceed. The petition shall set forth the specific factual and/or legal reason(s) for the appeal.~~ A copy of the petition ~~and of the Declaration of Readiness to Proceed~~ 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 ~~approval of a MPN Plan~~ 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.

(~~3~~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.

(~~4~~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) 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.

(7) 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.*

(b) If one of the circumstances in subdivision (a) exists, the Administrative Director shall notify the MPN applicant in writing of the specific ~~deficiencies~~ violations alleged. The Administrative Director shall allow the MPN applicant an opportunity to correct the ~~deficiency~~ violation and~~/or~~ to respond within ten days. If the Administrative Director determines that the ~~deficiencies~~ violations have not been cured, 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 ~~revoking~~ 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 ~~p~~ "Petition Appealing Administrative Director's Medical Provider Network Determination" with the Workers' Compensation Appeals Board pursuant to WCAB Rule 10959. ~~at the district office of the Workers' Compensation Appeals Board closest to the MPN applicant's principal place of business, together with a Declaration of Readiness to Proceed. The petition shall set forth the specific factual and/or legal reason(s) for the appeal.~~ A copy of the petition ~~and of the Declaration of Readiness to Proceed~~ 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 ~~Permanent~~ Current MPN Regulations; Reapproval

~~a. This section applies to MPNs that were approved by the Administrative Director pursuant to the emergency Medical Provider Network regulations effective November 1, 2004~~ (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, 2015. If the MPN is required to apply for reapproval before January 1, 2015, then the MPN shall update to the current regulations with its reapproval filing, whichever is sooner.

~~b. Employers or insurers whose MPNs were approved pursuant to the emergency Medical Provider Network regulations are not required to submit a Notice of MPN Plan Modification to comply with the new or revised sections of the permanent regulations, including:~~

~~1. Section 9767.3(d)(8)(C) or Section 9767.3(d)(16) regarding the contractual agreements contained in the Application for a Medical Provider Network Plan provisions.~~

~~2. Sections 9767.5(e)(1), (e)(2), (e)(3), (e)(4), 9767.5(h) and 9767.5(i) of the Access Standards provisions.~~

~~3. Section 9767.9(g) provision providing a timeline for the treating physician's report and what happens if the treating physician fails to issue a timely report contained in the Transfer of Ongoing Care into the MPN provisions.~~

~~4. Section 9767.10(b)(c) and (d) of the Continuity of Care provisions.~~

~~5. Section 9767.12(a), (a)(1), (a)(2), (a)(3), (a)(4) and (a)(5) of the Employee Notification provisions.~~

~~c. At the time an employer or insurer with an approved MPN pursuant to the emergency Medical Provider Network regulations submits a Notice of MPN Plan Modification, the employer or insurer shall be required to verify compliance with the sections of the MPN permanent regulations listed in subdivision (b) above.~~

(b) 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) After an MPN has been reapproved, the expiration of reapproval will be four years from the date of the most recent reapproval.

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

(5) Each filing for reapproval shall use geocoding software to create a separate map for each specialty for all listed providers within the service area to establish compliance with the access standards for the MPN geographic service area.

(6) The time frames for the review process for an application for reapproval will be the same as for an original application.

(7) 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 60-day review period.

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

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

9767.16 ~~Notice to Employee Upon Termination, Cessation of Use, or Change of Medical Provider Network~~ Medical Provider Network Complaints

~~(a) The Medical Provider Network Applicant is responsible for ensuring that each injured covered employee is informed in writing of the MPN policies under which he or she is covered and when the injured employee is no longer covered by the Applicant's MPN. The MPN Applicant shall ensure each injured covered employee is given written notice of the date of termination or cessation of use of its MPN. The written notice shall be provided to injured covered employees prior to the effective date of termination or cessation of use of the Applicant's MPN. The notices required by this section shall be provided in English and also in Spanish to Spanish speaking employees.~~

~~(1) The MPN Applicant whose MPN is being terminated or will cease to be used shall ensure that every injured covered employee is provided the following information prior to the termination or cessation of use of its MPN by a MPN Applicant or an insured employer:~~

~~(A) The effective date of termination or cessation of use of the Applicant's MPN.~~

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

~~(C) The address, telephone number, email address and an MPN website, (optional), of the MPN Contact who can address MPN questions.~~

~~(D) For periods when an employee is not covered by a MPN, an employee may choice a physician 30 days after the date the employee notified the employer of his or her injury.~~

~~(E)(2) The following language may be provided in writing to injured covered employees to give the required notice of termination or cessation of use of a MPN: "The <Insert MPN Name>~~

~~Medical Provider Network (MPN) will no longer be used for injuries arising after <Insert Date of MPN Termination or Cessation of Use>. 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. You may obtain more information at <Insert MPN Contact Phone Number, Address, Email Address, and MPN Website (optional).”~~

~~(3) The notice of MPN termination or cessation of use may be provided by mail or included on or with an employee's paystub, paycheck or distributed through electronic means, including email, 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 Independent Medical Review will end with the employee's coverage under the MPN.~~

~~(b) If a MPN Applicant or insured employer is changing MPN coverage to a different MPN, the MPN Applicant that is providing the new MPN coverage shall ensure that every injured covered employee is provided written notice of the following information prior to the effective date of coverage under that Applicant's MPN:~~

~~(1) That medical treatment for new work injuries will be provided through the Medical Provider Network as of the effective date of coverage unless the employee properly predesignates a physician or medical group prior to injury;~~

~~(2) The effective date of coverage under the new MPN;~~

~~(3) That existing work injuries may be covered under the prior MPN or may be transferred into the new MPN. The worker should check with the worker's claims adjuster for more information;~~

~~(4) That for periods when the worker 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;~~

~~(5) The MPN Contact's telephone number, address, email address, and an MPN website (optional), for the worker to obtain more information about using the MPN.~~

~~(c) The following language may be provided in writing to injured covered employees to give the required notice of the change of MPN coverage: “Unless you predesignate a physician or medical group prior to injury, your new work injuries arising on or after <INSERT EFFECTIVE DATE OF NEW MPN> will be treated by providers in a new Medical Provider Network, <INSERT NEW MPN NAME>. If you have an existing injury, you may be required to continue care under your prior MPN or you may be required to change to a provider in the new MPN. Check with your claims adjuster. For periods when you are not covered under a MPN, you may choose a physician 30 days after you've notified your employer of your injury. You may obtain~~

~~more information at <INSERT MPN CONTACT, PHONE NUMBR, ADDRESS, EMAIL ADDRESS, AND AN MPN WEBSITE (optional).”~~

~~(d) Notice of termination or cessation of use of a MPN may be combined with the notice of a change to new MPN coverage if the combined notice meets all the MPN regulatory requirements for termination or cessation of use of a MPN and for change of a MPN.~~

~~(e) Notices required by this section shall be provided in English and also in Spanish to Spanish speaking employees.~~

~~(f) The notice of a change of MPN coverage may be provided by mail or included on or with an employee's paystub, paycheck or distributed through electronic means, including email, if the covered employee has regular electronic access to email at work to receive this notice prior to the beginning of new 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 beginning of new MPN coverage.~~

~~(g) If a change in MPN coverage results in modifications to an MPN's plan application or results in the filing of a new MPN application, the MPN modification or new application filing shall be submitted to DWC pursuant to section 9767.8 or 9767.3, whichever is applicable. Distribution to injured covered employees of the notice of a change of MPNs shall occur after DWC's approval of a MPN modification or new MPN.~~

(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 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 by the MPN contact person 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. If there is no electronically stamped date recorded, then the date the request was transmitted.

(C) 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 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 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 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 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 or the complainant in order to conduct an investigation to determine the validity of the allegations. The MPN 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 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: Sections ~~59, 124,~~ 133, ~~138.3, 138.4,~~ 4616 ~~and 5307.3~~, Labor Code.

Reference: Sections ~~3550 and 4616.2,~~ 4616(b)(4), and 4616(b)(5), Labor Code.

Section 9767.16.5 DWC Medical Provider Network Complaint Form 9767.16.5 [see attached]

Authority: Sections 133 and 4616, Labor Code.

Reference: Sections 4616(b), and 4616, 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

(2) A systematic failure to meet access standards under 9767.5(a) through (d), by failing to have at least three physicians available for each commonly used specialty listed in the MPN application in at least two specific locations within the MPN geographic service area described in the MPN plan.

(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 fails to meet the access standards for specific locations within the geographic service described in its plan. 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 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 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 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 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 9767.17.5 DWC Petition for Suspension or Revocation of a Medical Provider Network Form 9767.17.5 [see attached]

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 section 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. Reasonable requests for information or documentary evidence by the DWC may include, but not be limited to, the following items:

(i) Proof the MPN applicant meets the eligibility requirements to have an MPN.

(ii) A copy of the MPN's most recent approved plan submission (new MPN application, reapproval application or modification) along with the cover page and all attachments.

(iii) A copy of the most current network provider listing.

(iv) The URL address of the MPN's network provider listing.

(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 during the last thirty (30) calendar days preceding the date of the DWC request.

(vi) Copies of the written MPN physician acknowledgements.

(3) The MPN 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

(a) The penalty amount that shall be assessed for each failure 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.*, is as follows:

(1) MPN filing requirements with DWC:

(A) Failure to file an original 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 an original Notice of MPN Plan Modification within five (5) business days of a change in the MPN applicant's eligibility status, $2,500.

(C) Failure to file an original 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 an original 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 information or a change in provider listing access or website information required by section 9767.12, $2,500.

(E) Failure to file an original 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 an original application 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, $1,000 for each 30 days or part thereof that the failure continues after the date of submission of the reapproval application.

(2) MPN notice requirements:

(A) Failure to provide the written MPN employee notification pursuant to section 9767.12(a) to an injured covered employee, $2,500, per occurrence.

(B) Failure to provide a complete or correct MPN notice required under section 9767.12 to an injured covered employee, $250 per occurrence up to $10,000.

(C) 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.

(D) Failure to provide the MPN Independent Medical Review notice, $500 for each employee for whom the notice is not provided when required.

(3) Network access requirements:

(A) Failure to perform at least quarterly updates to confirm the accuracy of the medical and ancillary provider listings, for each inaccurate entry, $250, up to a total of $10,000 per quarter.

(B) Failure to update reported inaccuracies in the network provider listing within thirty (30) days of notice to the MPN through the contact method stated on the provider listings, $500, up to a total of $5,000, per month.

(C) Failure to meet the access standards, including approved alternative access standards or approved out-of-network treatment, for a specific location within the MPN geographic service area or areas described in its MPN plan $5,000 for each geographic service area affected, up to a total of $50,000.

(D) Failure to respond to calls made to the MPN medical access assistant 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.

(E) Failure to ensure an appointment for non-emergency services for an initial treatment is available within 3 business days of the MPN applicant's receipt of a request for treatment within the MPN, $500 for each occurrence.

(F) Failure to ensure an appointment for non-emergency specialist services is available within 20 business days of the MPN applicant's receipt of a referral to a specialist within the MPN, $500 for each occurrence.

(G) Failure to provide at least a regional area listing of MPN providers or specialists to an injured covered employee upon request, $2,500 for each occurrence.

(4) 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) 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 and respond within ten days. If the Administrative Director determines that the violation has not been cured, 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.

(c) Penalty amounts may be mitigated upon written request to the Administrative Director by the MPN applicant. Mitigation will be determined based on the documentation of the MPN's 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, 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.

(d) 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.

(e) 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;

(f) 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.

(g) 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. A copy of the petition shall be concurrently served on the Administrative Director.

Authority: Sections 133 and 4616, Labor Code.

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