



California Workers' Compensation Institute

1111 Broadway Suite 2350, Oakland, CA 94607 • Tel: (510) 251-9470 • Fax: (510) 251-9485

December 26, 2013

VIA E-MAIL – DWCRules@hq.dir.ca.gov

Maureen Gray, Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th floor
Oakland, CA 94612

**RE: CWCI 1st 15-Day Comment on Modifications to Proposed MPN Regulations
Sections 9767.1 - 9767.19**

Dear Ms. Gray:

These written 15-day comments on modifications to proposed revisions to the Medical Provider Network (MPN) regulations are presented on behalf of the California Workers' Compensation Institute (CWCI) members. Institute members include insurers writing 70% of California's workers' compensation premium, and self-insured employers with \$42B of annual payroll (24% of the state's total annual self-insured payroll).

Insurer members of the Institute include ACE, AIG, Alaska National Insurance Company, AmTrust North America, Chubb Group, CNA, CompWest Insurance Company, Crum & Forster, Employers, Everest National Insurance Company, Farmers Insurance Group, Fireman's Fund Insurance Company, The Hartford, Insurance Company of the West, Liberty Mutual Insurance, Pacific Compensation Insurance Company, Preferred Employers Insurance Company, Springfield Insurance Company, State Compensation Insurance Fund, State Farm Insurance Companies, Travelers, XL America, Zenith Insurance Company, and Zurich North America.

Self-insured employer members are Adventist Health, Agilent Technologies, Chevron Corporation, City and County of San Francisco, City of Santa Ana, City of Torrance, Contra Costa County Schools Insurance Group, Costco Wholesale, County of San Bernardino Risk Management, County of Santa Clara Risk Management, Dignity Health, Foster Farms, Grimmway Enterprises Inc., Kaiser Foundation Health Plan, Inc., Marriott International, Inc., Pacific Gas & Electric Company, Safeway, Inc., Schools Insurance Authority, Sempra Energy, Shasta County Risk Management, Southern California Edison, Sutter Health, University of California, and The Walt Disney Company.

Introduction

Medical Provider Network

In 2004, the Legislature changed the definition of medical treatment, chose evidence based medicine as the standard of care in California, and created Medical Provider Networks to provide injured workers with the highest quality medical care. To incent employers to invest in and create special medical networks for their injured workers, the Legislature allowed employers to control medical care through the use of MPNs for the life of the claim. The state, by statute and regulation, would administer and oversee the networks to ensure consistent access and quality of care. This was a monumental shift in policy for the California workers' compensation system.

The reforms enacted in 2012 by SB 863 were intended to make the application process more efficient and effective, provide specific personnel within networks to assist the injured worker with securing appointments, require network physicians to acknowledge participation, strengthen an employer's ability to enforce treatment within an MPN, require the MPNs to review the quality of care continuously, and enforce MPN standards with administrative penalties.

CWCI research has shown that by 2011, 81% of the injured workers in the system were treated by a MPN providers and that treatment by an MPN provider is one of the top ten factors in controlling the cost of medical care.

Access Standards

In order for Medical Provider Networks to adequately serve injured workers, it is essential that medical care for the most common industrial injuries be readily available and efficiently deployed in accordance with the patient's needs. Standards that are unrealistically narrow and inflexible will only impair the network's ability to serve its patients. It has become abundantly clear since the advent of medical networks that one size does not fit all. The Institute continues to urge the AD to base the MPN time/distance access standards on those established for provider networks used by disability insurers because they are more flexible and more realistically address the needs of patients.

The Institute has previously recommended that MPNs include physicians primarily engaged in the treatment of occupational injuries and physicians of each type described in Labor Code section 3209.3, as required by the statute, to treat common injuries experienced by injured employees and that the MPN meet the access standards for common injuries, also required by statute.

The Institute recommended that the MPN regulations be based on the definitions and access standards established by the Insurance Commissioner for group disability insurance policies. Labor Code section 4616.7(c) establishes a group disability insurance policy as an approved MPN and the standards set forth for group disability are reasonable and relate more directly to the statutory standards for MPNs.

For example, CCR, Title 10, section 2240.1(c) addresses time/distance provider network access standards that the Insurance Commissioner requires for disability policies and agreements. Those standards require:

- primary care network providers with sufficient capacity to accept covered persons within 30 minutes or 15 miles of each covered person's residence or workplace," and
- medically required network specialists who are certified or eligible for certification by the appropriate specialty board with sufficient capacity to accept covered persons within 60 minutes or 30 miles of a covered person's residence or workplace.

Primary care physician is defined in CCR, Title 10, section 2240(k) as:

- A physician who is responsible for providing initial and primary care to patients, for maintaining the continuity of patient care or for initiating referral for specialist care. A primary care physician may be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist or family practitioner.

By specifically including disability insurance groups in section 4616.7(c), the Legislature also approved the access standards set by the Insurance Commissioner. There is no statutory requirement for an MPN to include three physician specialists within the time/distance access standards and there is no need for workers' compensation provider networks access standards to exceed or differ from those required for disability insurers. The Institute continues to urge the AD to base the MPN time/distance access standards on those established for provider networks used by disability insurers.

Physicians Necessary to Treat Common Industrial Injuries

Labor Code section 4616(a) requires an adequate number and type of physician to treat common injuries. The most common California workers' compensation injuries in 2010, 2011 and 2012 identified in CWCI's ICIS database are listed in Table A in frequency order.

Table A – Common California Workers' Compensation Injuries by Frequency

Common WC injuries	2010	2011	2012	2010-2012
Minor wounds & injuries	21.1%	21.7%	21.6%	21.4%
Medical back problems w/o spinal cord involvement	19.0%	18.6%	18.5%	18.7%
Sprain of shoulder, arm, knee, lower leg	14.4%	14.7%	15.7%	14.9%
Ruptured tendon, tendonitis, myositis, bursitis	6.0%	6.0%	5.7%	5.9%
Joint pain	4.5%	4.7%	4.6%	4.6%
Wound or fracture of shoulder, arm, knee, lower leg	3.1%	3.2%	3.2%	3.2%
External eye disorders	2.9%	2.9%	2.8%	2.8%
Trauma of fingers, toes	2.4%	2.3%	2.5%	2.4%
Total	73.4%	74.1%	74.6%	73.9%

The list of common injuries in Table A is relevant for most MPNs including those used by insurers that provide statewide homogenous coverage.

The Institute's prior comments and recommendations below are intended to establish the necessary flexibility to allow medical networks to provide injured workers with the best medical care as promptly as possible, within or outside the network. The statutory provisions creating medical networks in the workers' compensation system are directed by the exigencies of the injured worker's medical needs and the regulations must follow the directions of the Legislature.

Regulatory Authority

The task imposed on state agencies by Government Code section 11342.2 is often very delicate. The statute states:

"Whenever by the express or implied terms of any statute a state agency has authority to adopt regulations to implement, interpret, make specific or otherwise carry out the provisions of the statute, no regulation adopted is valid or effective unless consistent and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute."

The proposed network access standards and the penalty scheme contained in the proposed regulations restrict the scope of statute authorizing the creation and use of Medical Provider Networks. The problem, simply stated, is that the threat of excessive access standards and penalties will curtail legitimate network operations that the statute permits.

It is the responsibility of the Administrative Director (AD) to interpret Labor Code section 4616 et seq. to make it specific and to enforce its dictates. At the same time, the AD must permit section 4616 to function at all levels in order to attain its legislative goals. Administrative regulations that alter or amend statute or enlarge or impair its scope are void, and courts not only may, but it is their obligation, to strike down such regulations. The Supreme Court has ruled that if the meaning of statute is clear and the regulations are in conflict with the plain meaning, regulations are void. Morris v. Williams (1967) 63 CR 689, 67 C2d 733, 433 P.2d 697.

An example of this conflict, is the requirement in Labor Code section 4616(a)(1) that the physician access standards be based on “physician type,” not specialty. The statute defines physician type with reference to Labor Code section 3209.3, physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractors, and the other providers described in Labor Code section 3209.5. The statute cannot be clearer. The judicial interpretation of the authority of the regulator is equally clear – the proposed regulation expands the scope of the statute and is invalid and unenforceable.

The art of crafting proper regulations requires that the state agency focus on the provisions of the statute. As is true of all regulations, the Division of Workers’ Compensation (DWC) must implement, interpret, and make specific the statutory provisions of Labor Code section 4616. The resulting regulations must be consistent with and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute.

Penalties

The Institute supports the concept of a single application for a single MPN that may be accessed by multiple users, and regulations that include definitions and enforcement standards that will facilitate rather than discourage their use. Regulations implementing this concept will simplify the application process and eliminate unnecessary work for the Division, MPN applicants and MPN users. The Institute supports the adoption of regulatory language clarifying that penalties are assessed against the MPN applicant rather than each individual user of the MPN so that there is no unintended multiplication of penalty assessments.

While the enabling statute clearly allows the AD to enforce the statutory provisions and the implementing regulations with administrative penalties, the Institute is concerned that an overly aggressive penalty structure will cause legitimate MPNs to drop out of the workers’ compensation system and prevent medical networks from using the statutory tools that the Legislature provided to achieve the highest quality of care. The networks will not want run the risk of incurring excessive and unreasonable penalties. Physician network access standards that dilute network quality and the penalty provisions taken together threaten to terminate the effective use of MPNs and reverse, by regulatory fiat, the Legislature’s social policy decision to allow employers to control medical care through the use of Medical Provider Networks.

The physician access standards must, therefore, be consistent with Labor Code section 4616. The penalty provisions must not prohibit or impede the delivery of medical care through the Medical Provider Network that is mandated or permitted by the statute. “[a] regulation that is inconsistent with the statute it seeks to implement is invalid.” Mendoza v WCAB (2010) En Banc Opinion 75 CCC 63.

The legislative intent underlying the creation of the Medical Provider Networks and the effort to make them more efficient and more accountable is clear. The scope and breadth of the proposed regulations is a threat to the development of new MPNs, to the continued viability of large and small networks, and to all of the positive outcomes established since their inception.

The Institute appreciates the impact penalties have as a deterrent to non-compliance, but there is a difference between a deterrent to non-compliance and an impediment to the legitimate operation of an MPN. We recommend limiting penalties to those activities that have a detrimental impact on the operation of the MPN, adopting penalties that are proportionate to the violation and to other penalties, instituting a penalty cap for each review period, and including provisions for mitigation as permitted under other administrative penalty provisions. The Administrative Director can achieve compliance and accountability with a more reasonable penalty schedule.

Recommended specific modifications are indicated by underline and ~~strikethrough~~, and discussion by *italics*.

Regulations

Section 9767.1 Medical Provider Networks – Definitions:

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

The term “legal” is unclear and should be struck or defined.

The term “contracting” should be replaced with the term “providing,” which is used in Labor Code section 4616(b)(3)(1). Harmonizing this language will reduce disputes and confusion over which types of entities fit within the definition.

We suggest using the term “managed care entities.” The term “network” could imply that these entities have direct contracts with medical providers which may not be the case in all situations. A managed care entity’s MPN may include medical providers under direct contract with the MPN and medical providers accessed through a contract(s) with a “traditional” provider network.

The claims administrator is the entity that that administers the claims. A claims administrator may use one or more MPNs to deliver medical treatment to injured employees. Using the term “claims administrator” is clear and simple. If the Division decides to list claims administrator types, the Institute recommends adding “third party administrator,” and either adding “State Compensation Insurance Fund” to the proposed listing, or since the definition of insurer in (a)(13) includes “the California

Insurance Guaranty Association,” deleting “the California Insurance Guaranty Association.”

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

See discussion in (a)(25)(C) regarding type of physician.

(a)(16) “Medical Provider Network Medical Access Assistant” means an individual in the United States whose primary duty is to assist injured workers with finding available Medical Provider Network physicians and with scheduling provider appointments, but unless the assistant is also an adjuster, may not authorize payment of goods or services.

The recommended modification clarifies that a medical access assistant does not authorize payment for goods or services.

(a)(19) “MPN Applicant” means a claims administrator an insurer or employer as defined in subdivision (36)s (6) and (13) of this section, or an entity that provides physician network services as defined in subdivision (7), who that is legally responsible for the Medical Provider Network.

This proposed change together with the recommended addition of (a)(36) will allow a third party administrator (TPA) to submit an application for an MPN that can be used by its clients. This will eliminate unnecessary duplicate filings by the clients of TPAs. See also comment on the recommended addition of (a)(36).

The term “legally” is unnecessary and unclear. It should be struck or defined.

(a)(25)(C) If the listing described in either (A) or (B) does not provide a minimum of three physicians of each specialty type, then the listing shall be expanded by adjacent counties or by 5-mile increments until the minimum number of physicians per specialty type are met.

Labor Code section 4616(a)(1) states:

“... The provider network shall include an adequate number and type of physicians, as described in Section 3209.3, or other providers, as described in Section 3209.5, to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged, and the geographic area where the employees are employed.”

The most common California workers' compensation injuries in 2010, 2011 and 2012 identified in CWCI's ICIS database are listed in Table A in order of frequency. Labor Code section 4616(a) requires an adequate number and type of physician to treat common injuries. The list of common injuries in Table A is relevant for most MPNs including those used by insurers that provide statewide homogenous coverage.

Table A – Common California Workers' Compensation Injuries by Frequency

Common WC injuries	2010	2011	2012	2010-2012
Minor wounds & injuries	21.1%	21.7%	21.6%	21.4%
Medical back problems w/o spinal cord involvement	19.0%	18.6%	18.5%	18.7%
Sprain of shoulder, arm, knee, lower leg	14.4%	14.7%	15.7%	14.9%
Ruptured tendon, tendonitis, myositis, bursitis	6.0%	6.0%	5.7%	5.9%
Joint pain	4.5%	4.7%	4.6%	4.6%
Wound or fracture of shoulder, arm, knee, lower leg	3.1%	3.2%	3.2%	3.2%
External eye disorders	2.9%	2.9%	2.8%	2.8%
Trauma of fingers, toes	2.4%	2.3%	2.5%	2.4%
Total	73.4%	74.1%	74.6%	73.9%

Physician types are described in Section 3209.3 as physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractors; and the other providers described in Section 3209.5 include physical therapists.

Authority

When the statutory language is clear and unambiguous, there is no room for interpretation and the statutory language must prevail. Per DuBois v WCAB (1993) 58 CCC 286, a regulation must be: 1) within the scope of the authority conferred by the statute; and 2) reasonably necessary to effectuate the purpose of the statute; see: Woods v Superior Court (1981) 28 Cal 3d 668, where the Supreme Court held that regulations that exceed the scope of the enabling statute are invalid and have no force or life.

In Mendoza v WCAB (2010) en banc opinion 75 CCC 634, the Board found the Administrative Director's rule invalid and held:

"... no regulation adopted is valid or effective unless consistent and not in conflict with the statute." ... An administrative agency has no discretion to promulgate a regulation that is inconsistent with the governing statutes."

In this instance, the Administrative Director has defined "physician type" to mean "specialty," even though the statute specifically defines physician type by reference to sections 3209.3. The result has been to make the physician access standards considerably more difficult and costly to meet and the networks larger and less effective. It is clearly an impermissible expansion of the Administrative Director's authority to set a standard for the number of physicians by specialty, instead of by type. As the Supreme Court has ruled, an administrative agency has no discretion to promulgate a regulation that is inconsistent with the governing statutes. The Administrative Director needs to rectify this standard.

MPN listings will continue to identify physician specialties, but a correction to the regulation will allow MPNs to determine the number necessary for each specialty, instead of being artificially constrained by a minimum number for each, no matter the need. This will ensure better, more flexible networks.

(a)(36) “Claims administrator” means an employer as described in subdivision (6), an insurer as defined in subdivision (13) or a third party administrator (TPA) acting on behalf of an insurer or employer.

This definition is necessary to efficiently and completely describe the type of entities that administer claims, and that may serve as an MPN applicant, in addition to an entity that provides physician network services.

See also comment on (a)(19).

If this recommendation is accepted, the definitions in this section will need to be re-ordered alphabetically.

(a)(37) “Primary care physician” means a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist or family practitioner.”

This definition is adapted from the definition in the Insurance Commissioner’s regulation Title 10, CCR, section 2240(k). Title 10, CCR, section 2240.1(c) addresses time/distance provider network access standards that the Insurance Commissioner requires for disability policies and agreements. Section 2240(k), is necessary to implement the Institute’s recommendation to apply those time and distance access network standard for primary care physicians in section 9767.5(b).

If accepted, the definitions in this section will need to be re-ordered alphabetically.

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

(b) Within **180-60** days of the Administrative Director’s receipt of a complete plan for reapproval, the Administrative Director shall approve for a four-year period or disapprove the complete plan for **reapproval-reapproval** based on the requirement of Labor Code section 4616 et seq. and this article. A plan for reapproval shall be considered complete if it includes correct information responsive to each applicable subdivision of section 9767.3. If the Administrative Director has not acted within **180-60** days of receipt of a complete plan for reapproval, it shall be deemed approved on the **18161**st day for a period of four years.

It is not necessary for the Administrative Director to allow six months for a review of a complete plan for MPN approval. More than 60 days is not needed for such review and approval. Only 60 days is allowed for review of a new application and the time needed to review of a plan for reapproval is expected to take less time than for a new application. A plan for reapproval that waits six months for approval may become outdated or obsolete before it is approved.

Section 9767.3 Requirements for a Medical Provider Network Plan

(a) As long as the application for a medical provider network plan meets the requirements of Labor Code section 4616 et seq. and this article, nothing in this section precludes ~~an employer or insurer a claims administrator~~ or entity that provides physician network services from submitting for approval one or more medical provider network plans in its application.

The recommended language will allow a TPA to submit an application for one or more MPNs that can be used by its clients. This will eliminate unnecessary duplicate filings. See also the comments regarding 9767.1(a)(35) and 9767.1(a)(19).

(c) All MPN applicants shall complete the section 9767.4 Cover Page for Medical Provider Network Application or Plan for Reapproval with an original signature, and an MPN Plan meeting the requirements of this section or the optional MPN Application form. The completed application or plan 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 Plan for Reapproval. Electronic signatures in compliance with California Government Code section 16.5 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.

Nothing in this section precludes an MPN applicant from submitting an application for approval of an MPN for the benefit and use of multiple claims administrators. If an MPN is accessed by an entity other than the MPN Applicant, the MPN application shall include a list of those entities pursuant to Section 9767.3(d)(7).

The cover page requirements are not clear for Applications and Plans for Reapproval that are submitted with electronic signatures. The Institute suggests clarifying whether or not a hard copy with original signature must be maintained in those circumstances.

In addition, the Institute recommends adding the highlighted language to this section to clarify that an MPN applicant may submit an application for an MPN that can be accessed by multiple entities. This will eliminate unnecessary duplicate filings.

(c)(2) The network provider information shall be submitted on a disk(s), CD ROM(s), or a flash drive, and the provider file shall have only the following eight columns. These columns shall be in the following order: (1) physician name (2) specialty type (3) physical address-(4) city (5) state (6) zip code (7) any MPN medical group affiliations and (8) an assigned provider code for each physician listed. If a physician falls under more than one provider code, the physician shall be listed separately for each applicable provider code. The following are the provider codes to be used: primary treating physician (PTP), orthopedic medicine (ORTHO), chiropractic medicine (DC), occupational medicine (OCCM), acupuncture medicine (LAC), psychology (PSYCH), pain specialty medicine (PM), occupational therapy medicine (OT), psychiatry (PSY), neurosurgery (NSG), family medicine (GP), neurology (NEURO), internal medicine (IM), physical medicine and rehabilitation (PMR), or podiatry (DPM). If the specialty does not fall under any one of the previously listed categories, then the specialty shall be clearly identified in the specialty column and the code used shall be (MISC). By submission of its provider listing, the applicant is affirming that all of the physicians listed have been informed that the Medical

Treatment Utilization Schedule (“MTUS”) is presumptively correct on the issue of the extent and scope of medical treatment and diagnostic services and have a valid and current license number to practice in the State of California.

See the comment on section 9767.1(a)(25)(C) regarding physician type versus physician specialty.

The necessity for the newly proposed “provider codes” in the second sentence is not clear. If these codes are meant to identify providers that generally treat common injuries experienced by injured employees as referenced in Labor Code section 4616(a), then the Institute suggest revising the access standards in these regulations to require at least three physicians in each these provider code categories in lieu of each specialty. If this is not the case, then the Institute recommends deleting this highlighted section since it is not necessary.

(c)(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.

We suggest restoring this section to accommodate MPN applicants who choose to include medical groups in their networks. Doing so will make compliance for both the MPN applicants and the selected groups less onerous. If this recommendation is accepted, the section must be renumbered.

(d)(8)(G) Provide a listing of the name, **specialty type**, and location of each physician as described in Labor Code Section 3209.3, **and medical groups** who will be providing occupational medicine services under the plan. **Only individual physicians in the MPN shall be listed, but** MPN medical group affiliation(s) may be included with each individual physician listed. By submission of the application, the MPN applicant is confirming that a contractual agreement exists with the physicians, providers or medical group practice in the MPN to provide treatment for injured workers in the workers' compensation system and that the contractual agreement is in compliance with Labor Code section 4609, if applicable.

MPN physician listings will include a physician’s specialty to enable an injured employee to select “a treating physician and any subsequent physicians based on the physician’s specialty or recognized expertise in treating the particular injury or condition in question.” However, while it is necessary to submit the physician type in an MPN application so that the Administrative Director can validate that access standards by type of physician are met pursuant to Labor Code section 4616(a)(1), there is no such statutory basis or necessity for also requiring the applicant to report the specialty in the MPN application. See in addition the comment on section 9767.1(a)(25)(C) regarding physician type versus physician specialty.

As also suggested in (c)(4), the other modifications will accommodate MPN applicants who choose to include medical groups in their networks. This will make compliance for both the MPN applicants and the selected groups less onerous.

(d)(8)(H) Provide an electronic copy in Microsoft Excel format of the geocoding results of the MPN provider directory to show compliance with the access standards for the injured workers being covered by the MPN. The geocoding results shall include the following separate files: 1) a complete list of all zip codes within the MPN geographic service area; 2) a narrative and/or graphic report that establishes that there are at least three available primary treating physicians within the fifteen-mile access standard from the center of each zip code within the MPN geographic service area; 3) a narrative and/or graphic report that establishes that there is a hospital or an emergency health care service provider within the fifteen-mile access standard from the center of each zip code within the MPN geographic service area; 4) a narrative and/or graphic report that establishes that there are at least three available specialist types of physicians described in Labor Code section 3209.3 to provide occupational health services in each listed specialty to treat common injuries experienced by injured employees engaged in the type of occupation or industry within the thirty-mile access standard from the center of each zip code within the MPN geographic service area; 5) a list of all zip codes in which there is a health care shortage and where the access standards are not met for each specialty and an explanation of how medical treatment will be provided in those areas not meeting the access standards; and 6) each physician listed in the MPN provider directory listing shall be assigned at least one provider code as set forth in subdivision (c)(2) of this section to be used in the geocoding reports.

Labor Code section 4616(b)(3) requires MPNs to submit geocoding for reapproval “to establish that the number and geographic location of physicians in the network meets the required access standards.” Labor Code section 4616(a)(1) requires an adequate number and type of physicians to treat common injuries, and that the number of physicians be sufficient to enable timely treatment. It does not require the same number of physicians in each area, nor does it require access standards by specialty.

See in addition the comment on section 9767.1(a)(25)(C) regarding physician type versus physician specialty.

See also the comment on section (c)(2). The purpose of the newly proposed provider codes is not clear for this section as well and appears to be unnecessary.

§9767.4. Cover Page for Medical Provider Network Application or Plan for Approval

4. Eligibility Status of MPN Applicant

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

The proper abbreviation for State Compensation Insurance Fund is “State Fund” and not “SCIF.”

See comments on MPN Applicant in section 9767.1(a)(19) regarding TPAs.

Section 9767.5 Access Standards

The Institute continues to urge the Administrative Director to consider the access standards based on the Insurance Commissioner's standards that were recommended by the Institute in its written testimony on the proposed revisions to the MPN regulations.

(a) An MPN ~~must have at least three available~~ shall include physicians primarily engaged in the treatment of occupational injuries, and physicians of each specialty type described in Labor Code Section 3209.3 to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged and within the access standards set forth in (1) and (2). An MPN shall meet the access standards for those physician types.

CCR, Title 10, section 2240.1(c) addresses time/distance provider network access standards that the Insurance Commissioner requires for disability policies and agreements. Those standards require "primary care network providers with sufficient capacity to accept covered persons within 30 minutes or 15 miles of each covered person's residence or workplace," and "medically required network specialists who are certified or eligible for certification by the appropriate specialty board with sufficient capacity to accept covered persons within 60 minutes or 30 miles of a covered person's residence or workplace." Primary care physician is defined in CCR, Title 10, section 2240(k) as "a physician who is responsible for providing initial and primary care to patients, for maintaining the continuity of patient care or for initiating referral for specialist care. A primary care physician may be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist or family practitioner."

There is no necessity for workers' compensation provider network time/distance access standards to exceed or differ from those required by the Insurance Commissioner for provider networks used by disability insurers, and there is no statutory requirement for an MPN to include three physicians within the time/distance access standards. We note that a group disability insurance policy pursuant to Labor Code section 4616.7(c) is deemed an approved MPN. The Institute recommends basing the MPN time/distance access standards to those that apply to provider networks used by disability insurers.

It is not clear what is meant by "available physician." If the term remains, it will generate unnecessary disputes over whether or not a physician is "available."

See the comment on section 9767.1(a)(25)(A) regarding physician specialty.

The Institute recommends moving the reference to providers of occupational health services to this subdivision (a) from subdivision (c) since the specific access standards are required only for the physician types described in Labor Code section 3902.3.

Labor Code section 4616(a) requires an adequate number and type of physician to treat common injuries. The most common California workers' compensation injuries in 2010, 2011 and 2012 identified in CWCI's ICIS database are listed in Table A in frequency order.

Table A – Common California Workers’ Compensation Injuries by Frequency

Common WC injuries	2010	2011	2012	2010-2012
Minor wounds & injuries	21.1%	21.7%	21.6%	21.4%
Medical back problems w/o spinal cord involvement	19.0%	18.6%	18.5%	18.7%
Sprain of shoulder, arm, knee, lower leg	14.4%	14.7%	15.7%	14.9%
Ruptured tendon, tendonitis, myositis, bursitis	6.0%	6.0%	5.7%	5.9%
Joint pain	4.5%	4.7%	4.6%	4.6%
Wound or fracture of shoulder, arm, knee, lower leg	3.1%	3.2%	3.2%	3.2%
External eye disorders	2.9%	2.9%	2.8%	2.8%
Trauma of fingers, toes	2.4%	2.3%	2.5%	2.4%
Total	73.4%	74.1%	74.6%	73.9%

The list of common injuries in Table A is relevant for most MPNs including those used by insurers that provide statewide homogenous coverage. These common injuries are treated by primary care physicians as defined in the Insurance commissioner regulations and as described in the recommended definition. See comment on section 9767.1(a)(37).

(a)(1) An MPN must have at least three available primary treating care physicians and a hospital for emergency health care services, or if separate from such hospital, a provider of all emergency health care services, within 30 minutes or 15 miles of each covered employee's residence or workplace.

There is no statutory authority for specific access standards for a hospital for emergency health care services or a provider of all emergency health care services. In addition, while most, if not all MPNs include and will continue to include such facilities, there is no necessity for requiring them to be included in the access standards because subsection (j) requires “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.”

Common workers’ compensation injuries are treated by primary care physicians as defined in the Insurance commissioner regulations and as described in the recommended definition. See the comments in (a) on common injuries and Table A above. See also comment on section 9767.1(a)(37).

(a)(2) An MPN must have the types physicians described in Labor Code section 3209.3 to who can treat common injuries experienced by the covered injured employees within 60 minutes or 30 miles of a covered employee's residence or workplace.

Since access standards are required only for the physician types described in Labor Code section 3902.3, the Institute recommends moving the reference to providers of occupational health services to (a).

See in addition the comments on section 9767.1(a)(25) and 9767.5(a).

(a)(3) Notwithstanding (b) and (c), these requirements are not intended to prevent the injured employee from selecting from the nearest three physicians of that type in the network, or selecting physicians as allowed by their network beyond the applicable geographic area specified by these standards.

This recommended subsection is adapted from the language in CCR, Title 10, section 2240.1(c)(6). It will ensure that injured employees have a choice of at least three physicians of that type.

If this section is inserted here as the Institute recommends, subsequent subdivisions (d) through (j) must be re-alphabetized.

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

(b) If an MPN applicant is unable to meet the network access standard(s) required by this section due to the absence of physicians willing to treat workers' compensation injuries located within sufficient geographic proximity to covered employees, the MPN applicant may propose an alternative mileage standard in its application or may specify that the injured covered employee may select a physician of that type outside the MPN within a reasonable geographic area until the MPN is able to provide the necessary treatment through an MPN physician. Such a proposal shall include, at a minimum, a description of the affected area and covered employees in that area, how the applicant determined the absence of practicing providers, and how the proposal will ensure the availability of treatment for injured covered employees who work and reside in that area.

LC section 4616(a)(2) specifies that medical treatment for injuries must be available and accessible to the extent feasible at reasonable times to all covered employees. This proposed alternative language is based on language in CCR, Title 10, section 2240.1(c)(7). The MPN time and distance access standards language should parallel, to the extent feasible, the language of section 2240.1's time and distance access standards. It is reasonable for the MPN applicant to propose either an alternative mileage standard or to permit the injured employee to select a physician of that type outside the MPN within a reasonable geographic area until the MPN is able to provide the treatment through an MPN physician.

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

We suggest removing "to the employer or" as the MPN would have no way of ensuring treatment within the required timeframe if notification was to the employer. The trigger should be when the MPN applicant is notified, as noted in the current regulations, or upon notice to the medical access assistant.

(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 initial appointment with a specialist in an appropriate referred specialty is available within 20 business days of a covered employee's ~~notice to the MPN medical access assistant that treatment is needed. a covered employee's reasonable requests for an appointment directly with a physician or through an MPN medical access assistant. If an MPN medical access assistant is unable to schedule a timely medical appointment with an appropriate specialist within five business days of an employee's request, the employer shall permit the employee to obtain necessary treatment with an appropriate specialist outside of the MPN.~~

We suggest using the same standard set forth in 9767.5 (f). The requirement should start when the covered employee notifies the MPN applicant or its medical access assistant. Having the requirement start when a request is made to a physician is not consistent with the regulations. The physician that the covered employee selects may not have availability within the timeframe, but there may be other appropriate physicians with availability within required access standard. In addition, the requirement to authorize out of network care if an appointment is not made within 5 days of a request should be removed. Not only does this dilute the established access standard of 20 business days, it does not take into account delays that are not due to the medical access assistant, such as when the covered employee doesn't respond timely to requests from the medical access assistant.

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

There is no statutory requirement to provide a Spanish-speaking MPN access assistant. Interpreter services can be provided if needed.

~~(1) There shall be at least one MPN access assistant 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.~~

There is no statutory requirement for voice messaging, faxes or messages. This subsection is not necessary.

(2) ~~Unless the MPN medical access assistant is also a claims adjuster the MPN medical access assistants do may not authorize treatment and have different duties than claims adjusters. The MPN medical assistants are not to function as claims adjusters. However, the assistants shall work in coordination with the MPN Contact and the claims adjuster(s) to ensure timely and appropriate medical treatment is provided to the injured worker.~~

The Institute appreciates the clarification that the duties of a medical access assistant do not include authorizing payment for treatment; however it should be clear that an adjuster who is also acting as a medical access assistant, may do so.

It is not appropriate to mandate workflow, coordination or similar matters of internal administration.

Section 9767.5.1 Physician Acknowledgements

(a) Each physician in an MPN, unless the physician is a shareholder, partner, or ~~employer~~~~employee~~ of a medical group that elects to be part of the MPN, shall have a written acknowledgment that the physician elects to participate in a California workers' compensation medical provider network. The acknowledgment by the physician shall comply with subdivisions (b) and (c). The acknowledgment(s) by the physician shall either specify the MPN or MPNs in which the physician is or will be participating or authorize the agent or designee of a medical group to act on the physician's behalf to specify the MPN or MPNs in which the physician is or will be participating. If the physician authorizes a medical group's agent or designee, the specification of MPNs by the medical group's agent or designee shall comply with subdivision (d).

The recommended revision will correct a typographical error.

(d) A single written group acknowledgment may be submitted for a medical group participating in an MPN by the medical group's agent or designee on behalf of MPN participating physicians in the medical group ~~who are shareholders, partners, or employees of the medical group or who have executed individual acknowledgments in accordance with subdivisions (a) and (b).~~ Each medical group acknowledgment shall include a list of all physicians in the medical group and shall affirm that each physician listed has agreed to participate in the MPN. When a physician listed on the group acknowledgment is no longer participating in the MPN or when new members join the medical group, then the medical group acknowledgment shall be updated with a new master list of MPN participating physicians in the medical group. This amendment shall be submitted to the MPN within thirty days of the effective date of the change. The medical group's agent or designee shall affirm that each listed physician in the updated list is participating in the MPN or MPNs as indicated on the list. The acknowledgment must clearly specify the time frame of the acknowledgment, which may continue for as long as the medical group's MPN contract is effective. A new acknowledgment shall be submitted with a new or renewed MPN contract. Electronic signatures in compliance with California Government Code section 16.5 are acceptable.

4616(a)(3) contains a provision that the acknowledgement form may be signed by an authorized employee of the physician or the physician's office. The section refers to "a

medical group that elects to be part of the network” which indicates that a medical group as a whole may participate in an MPN.

The requirement in 9767.5.1(d) conflicts with the statute by limiting group acknowledgement to physicians in the medical group who have executed individual acknowledgements or who are shareholders, partners, or employees of the medical group. The requirement that each physician signs an acknowledgement for the medical group is a limitation that is administratively burdensome and not contained in the enabling statute. Under 4616(a)(3), if the medical group acknowledges participation and the MPN lists the medical group as a whole in the network, that is all that is required. If the MPN selects only specific providers from a medical group, then each provider would be required to sign a separate acknowledgement.

Section 9767.8 Modification of Medical Provider Network Plan

Section (a) needs to be renumbered as it is missing (8) and (9). The section should be (a)(1) through (a)(13).

Section 9767.12 Employee Notification.

(a) When an injury is reported or an employer has knowledge of an injury that is subject to an MPN or when an employee with an existing injury is required to transfer treatment to an MPN, a complete written MPN employee notification with the information specified in paragraph (2) of this subdivision, shall be provided to the covered employee by the employer or the insurer for the employer claims administrator. This MPN notification shall be provided to employees in English and also in Spanish if the employee primarily speaks Spanish and does not proficiently speak or understand the English language.

The first recommended modification will clarify that the injury is subject to an MPN.

The claims administrator (the entity adjusting the claim) may also provide the notification.

The notice in Spanish is only necessary if the employee does not proficiently speak or understand the English language. There is no necessity to provide a notice in Spanish if the employee proficiently speaks and understands English, even if the employee primarily speaks Spanish.

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

This phrase is not necessary.

(a)(2)(A) How to contact the person designated by MPN applicant to be the MPN Contact for covered employees to answer questions about the use of MPNs and to address MPN complaints. The employer or insurer shall provide a toll-free telephone number with access to the MPN Contact if the MPN geographical service area includes more than one area code. A toll-free number must also be listed for MPN Medical Access Assistants, with a description of the access assistance they provide, including finding available physicians and scheduling **and confirming** physician appointments, and the times they are available to assist workers with obtaining access to medical treatment under the MPN;

Confirming appointments is not a duty that is required by statute.

(a)(2)(B) A description of MPN services as well as the The MPN's web address for the directory of MPN providers more information about the MPN and the MPN's approval number;

The statute requires a web address on for the listing of providers that is in the directory.

Section 9767.15 Compliance with Current MPN Regulations; Reapproval

(b)(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. MPNs most recently approved on or before January 1, 2011 will be deemed approved until **December 31, 2014 twelve months from the date the regulations are filed with the Secretary of State, or the effective date of these regulations, whichever is later.** Reapprovals for these MPNs shall be filed no later than **June 30, 2014 six months from the date the regulations are filed with the Secretary of State, or the effective date of these regulations, whichever is later.**

These revisions are recommended because the anticipated filing and effective dates are uncertain and anticipated to be later than expected.

(b)(5) Each filing for reapproval shall meet the requirements for geocoding as follows: Provide an electronic copy in Microsoft Excel format of the geocoding results of the MPN provider directory to show compliance with the access standards for the injured workers being covered by the MPN. The geocoding results shall include the following separate files: 1) a complete list of all zip codes within the MPN geographic service area; 2) a narrative and/or graphic report that establishes that there are at least three available primary treating physicians within the fifteen-mile access standard from the center of each zip code within the MPN geographic service area; 3) a narrative and/or graphic report that establishes that there is a hospital or an emergency health care service provider within the fifteen-mile access standard from the center of each zip code within the MPN geographic service area; 4) a narrative and/or graphic report that establishes that there are at least three available **specialist types of physicians described in Labor Code section 3209.3 to provide occupational health services in each listed specialty to treat common injuries experienced by injured employees engaged in the type of occupation or industry** within the thirty-mile access standard from the center of each zip code within the MPN geographic service area; 5) a list of all zip codes in which there is a health care shortage and where the access standards are not met for each specialty and an explanation of how medical

treatment will be provided in those areas not meeting the access standards; and 6) each physician listed in the MPN provider directory listing shall be assigned at least one provider code as set forth in subdivision (c)(2) of this section to be used in the geocoding reports.

Labor Code section 4616(b)(3) requires MPNs to submit geocoding for reapproval “to establish that the number and geographic location of physicians in the network meets the required access standards.” Labor Code section 4616(a)(1) requires an adequate number and type of physicians to treat common injuries, and that the number of physicians be sufficient to enable timely treatment. It does not require the same number of physicians in each area, nor does it require access standards by specialty.

See in addition the comment on section 9767.1(a)(25)(C) regarding physician type versus physician specialty.

See also the comment on section 9767.3(c)(2). The purpose of the newly proposed provider codes is not clear for this section as well and appears to be unnecessary.

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

(a)(2) That an MPN has systematically failed to meet access standards under 9767.5 at minimum, on more than onetwo occasions in at least two three specific access locations within the MPN geographic service area. Additionally, the petitioner must show that the MPN failed to ensure in each instance occurrence that a worker received necessary medical treatment within the MPN or and failed to authorize treatment outside of the MPN within the required time frames and access standards.

A systematic failure to meet access standards should equate to the MPN’s inability, overall, to meet regulatory and statutory requirements over a period of time. The basis for a petition to reasonably trigger an investigation should be more than just a couple of isolated incidents. Given the potential disruption to the medical care of multiple injured employees and the penalty (suspension or revocation), a minimum standard of two occasions in two locations as a baseline for submitting a petition is unreasonably low.

For a more reasonable red flag for investigating whether there is a systematic failure, each incident should involve a failure to both provide necessary treatment within the MPN and to authorize it out of network on at least three occasions in three locations.

(c)(2) Results of any and all attempts by petitioner to determine if the MPN has met the access standards on more than onetwo occasions for them at least three specific locations within the geographic service area or areas described in its plan without authorizing treatment outside the network.

As discussed in (a)(2), a petition should show a failure to both provide necessary treatment within the MPN and to authorize it out of network on at least three occasions in three locations.

Section 9767.17.5 DWC Petition to Suspend or Revoke an MPN Form

MPN ~~Contact~~Applicant Information

The Institute recommends changing on the form the “MPN Contact Information” to “MPN Applicant Information” and the subsequent references to “MPN Contact” to “MPN Applicant Liaison” as any such petition should go directly to the MPN applicant.

The MPN has systematically failed to meet MPN access standards pursuant to section 9767.5 on more than ~~one~~two occasions in at least ~~two~~three specific access locations within the MPN geographic service area. Each failure resulted in a worker being unable to obtain necessary treatment after the MPN has had a reasonable opportunity to remedy the access failure for each occasion and location.

The Institute recommends these modifications to the form because a petition should show a failure to both provide necessary treatment within the MPN and to authorize it out of network on at least three occasions in three locations, as discussed in the comments on section 9767.17 (a)(2).

Section 9767.18 Random Reviews

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

Random MPN reviews should occur in concert with and no more frequently than Claims PAR audits.

~~(a)(2)(B)(ii) A complete copy of the MPN’s most recent approved plan submission (new MPN application, reapproval plan or modification) including a copy of the most recent employee notification and MPN notices given to covered employees, and/or a listing of all plan filings to date after the effective date of this section.~~

It is not necessary to provide the most recent approved plan submission, cover page and all attachments as the Division already has them in its possession.

(a)(2)(B)(iii) A copy of the most recent network provider listing, the URL address of the MPN’s network provider listing, documentary evidence of quarterly updates to the provider listing for the past year and documentary evidence of timely corrections to the provider listing for inaccuracies reported to the MPN ~~within a reasonable time period through the contact method stated on the provider directory listing to report inaccuracies.~~

This modification is make this consistent with the requirements in 9767.12(a)(2)(C) where the contact method and period for response are specified.

(a)(2)(B)(iv) A copy of any MPN complaints or petitions for suspension or revocation received by the MPN and the MPN’s responses. ~~In addition, documentation of any administrative actions taken by the Administrative Director against the MPN within a reasonable time period may be requested.~~

This is not necessary because it is already in the possession of the Administrative Director.

~~(a)(2)(B)(v) A copy of the telephone call logs tracking the calls and the contents of the calls made to and by the MPN medical access assistants and the MPN Contact within a reasonable time period.~~

Telephone logs are not, and should not be required. If reference to telephone logs remains there must be clarification that telephone logs are optional, not required.

Section 9767.19 Administrative Penalty Schedule; Hearing, Mitigation and Appeal

The proposed penalty scheme contained in the proposed regulations restrict the scope of statute authorizing the creation and use of Medical Provider Networks. The problem, simply stated, is that the threat of excessive access standards and penalties will curtail legitimate network operations that the statute permits.

While the enabling statute clearly allows the AD to enforce the statutory provisions and the implementing regulations with administrative penalties, the Institute is concerned that an overly aggressive penalty structure will cause legitimate MPNs to drop out of the workers' compensation system and prevent medical networks from using the statutory tools that the Legislature provided to achieve the highest quality of care. The networks will not want run the risk of incurring excessive and unreasonable penalties. Physician network access standards that dilute network quality and the penalty provisions taken together threaten to terminate the effective use of MPNs and reverse, by regulatory fiat, the Legislature's social policy decision to allow employers to control medical care through the use of Medical Provider Networks.

The art of crafting proper regulations requires that the state agency focus on the provisions of the statute. As is true of all regulations, the Division of Workers' Compensation (DWC) must implement, interpret, and make specific the statutory provisions of Labor Code section 4616. The resulting regulations must be consistent with and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute.

The penalty provisions must not prohibit or impede the delivery of medical care through the Medical Provider Network that is mandated or permitted by the statute. "[a] regulation that is inconsistent with the statute it seeks to implement is invalid." Mendoza v WCAB (2010) En Banc Opinion 75 CCC 63.

The Institute appreciates the impact penalties have as a deterrent to non-compliance, but there is a difference between a deterrent to non-compliance and an impediment to the legitimate operation of an MPN. We recommend limiting penalties to those activities that have a detrimental impact on the operation of the MPN, adopting penalties that are proportionate to the violation and to other penalties, instituting a penalty cap for each review period, and including provisions for mitigation as permitted under other administrative penalty provisions. The Administrative Director can achieve compliance and accountability with a more reasonable penalty schedule.

Thank you for the opportunity to provide written testimony. Please contact me for further clarification or if I can be of any other assistance.

Sincerely,

Brenda Ramirez
Claims and Medical Director

BR/pm

cc: Christine Baker, DIR Director
Destie Overpeck, Acting Administrative Director
Dr. Rupali Das, Executive Medical Director
DWC Attorney Yu Yee Wu
DWC Attorney John Cortez
CWCI Claims Committee
CWCI Medical Care Committee
CWCI Legal Committee
CWCI Regular Members
CWCI Associate Members