



## California Workers' Compensation Institute

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VIA E-MAIL – DWCRules@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 Written Testimony on Proposed MPN Regulations  
Sections 9767.1 - 9767.19**

Dear Ms. Gray:

This written testimony on proposed revisions to the Medical Provider Network (MPN) regulations is 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, 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 Permanente, 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.

### 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, cited in detail below, 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.

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 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.

In addition, we suggest that the Administrative Director revise definitions to permit the filing of a single application for a single MPN, and that a single MPN may have multiple users. We suggest adding language to clarify that penalties, are assessed against the MPN applicant, not each individual user of the MPN. This change would prevent, what we believe would result in an unintended multiplication of penalty assessments.

As presently written, multiple applicants are obliged to file applications for the same MPN. For example, if an insurer has multiple underwriting companies that access the same MPN, each must submit a separate application. The Institute recommends that the Administrative Director modify its definitions, such as "MPN Applicant," and "Claims Administrator" to permit the filing of a single application for a single MPN. This will simplify the process and eliminate unnecessary work for both the Division and current applicants.

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

## Regulations

### **Section 9767.1 Medical Provider Networks – Definitions:**

(a)(1) “Ancillary services” means any provision of medical services or goods as allowed in Labor Code section 4600 by a non-physician, including **but not limited to** interpreter services, physical therapy, and pharmaceutical services.

*It is necessary to clarify that ancillary services are not limited to interpreter services, physical therapy, and pharmaceutical services to avoid disputes over whether or not ancillary services include those services.*

(a)(7) “Entity that provides physician network services” means an **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 claims administrators**, and that meets the requirements of this article, Labor Code 4616 *et seq.*, and corresponding regulations.

*An entity that employs or contracts with physicians and other medical providers makes the network available to claims administrators to deliver medical treatment to injured employees. The proposed language fails to take third party administrators (TPAs) into account. TPAs deliver medical treatment to injured workers on behalf of many self-insured employers and some insurers. See also the comment for (a)(35).*

*The word “legal” is not necessary and because its intended meaning is not clear it will cause confusion and disputes. If the word remains, its intended meaning must be clarified.*

(a)(12) “Health care shortage” means a situation in either a rural or non-rural area in which there is an insufficient number **and type** 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 **more than the minimum number of** non-MPN physicians **in that specialty of that type in the area who are available and willing to treat injured employees in accordance with California workers’ compensation laws** within the access standards.

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

*Non-MPN physicians who are not willing and available to treat injured employees in accordance with California workers’ compensation laws should not be counted when determining a health care shortage for workers’ compensation purposes.*

(a)(15) “Medical Provider Network Approval Number” means the unique number assigned by DWC to a Medical Provider Network **by name** upon approval and used to identify each approved Medical Provider Network.

*Clarifying that the Medical Provider Network Approval Number is attached to an MPN by name will eliminate confusion and will enable the use of a single identifier for an approved MPN, even if multiple log numbers are assigned for individual applications submitted to the Division to report the use of an approved MPN.*

*Further the Institute urges the Division to consider allowing each approved network to track and report to the Division the claims administrators who use its network. This will significantly reduce the administrative burden for the Division and users alike. Claims administrators will continue to report network use and payments to WCIS.*

*The MPN name is required in the employee notification document. The Division can also require the approval number to appear in the notification document if necessary, although the Institute believes that only the name is necessary.*

(a)(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, **but not including authorization for goods or services.**

*Clarification is needed that assistance does not imply authorization for goods or services.*

(a)(19) “MPN Applicant” means **a claims administrator an insurer or employer** as defined in subdivision **(35)s (6) and (13) of this section**, or an entity that provides physician network services as defined in subdivision (7); **that submits an application to the Division for approval or reapproval of an MPN.**

*The proposed change 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 (a)(35).*

(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**

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

*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)(27) “Revocation” means the ~~permanent~~ termination of a Medical Provider Network’s approval.

*There is no statutory prohibition barring a Medical Provider Network from submitting a new application after its approval was revoked. The term “permanent” here is not necessary and may fuel unintended controversy and litigation over whether an MPN is permanently barred from submitting a new application after its approval has been revoked.*

*The Institute recommends that the Division include on its listing the date an MPN’s approval was revoked.*

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

*The term “permanent” is not necessary for an MPN that has ceased to do business. An MPN that ceased to do business is not precluded from submitting a new application at a later date. The term “permanent” may fuel unintended and unnecessary litigation over whether an MPN that ceased to do business is permanently barred from submitting a new application.*

*The Institute recommends that the Division include on its listing the termination date of an MPN that has ceased to do business.*

~~(a)(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.~~

*The Institute suggests deleting this definition to avoid confusion and dispute because the term “treating physician” is used sometimes in these regulations to refer to the primary treating physician, sometimes to any physician who is providing treatment, and at other times to a physician who is treating but is not the primary-treating physician. Alternatively, where there is a need to identify a physician who is providing treatment but is not the primary treating physician, we suggest using the term “secondary physician” as it is defined in Section 9785(a)(2).*

(a)(34) “Withdrawal” means the ~~permanent~~ discontinuance of an approved MPN that was never implemented.

*The term “permanent” is not necessary when a discontinued MPN was never implemented. An MPN that was never implemented and was discontinued is not precluded from submitting a new application at a later date. The term “permanent” may fuel unintended and unnecessary litigation over whether a discontinued MPN is permanently barred from submitting a new application.*

*The Institute recommends that the Division include on its listing the withdrawal date of an MPN that was never implemented.*



(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 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 Application for Reapproval**

(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 expect to use the MPN in the future.

*While an applicant may wish to use the MPN in the future, it may not expect to do so. “Expect” is more accurate in this context and less subjective.*

## **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 a claims administrator or entity that provides physician network services from submitting for approval one or more medical provider network plans in its application.

*See comments on 9767.1 (35) and 9767.1(19)*



*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.*

**(c) 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 proposed language will 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. While it is necessary for entities that create MPNs to file MPN applications for approval or reapproval of MPNs, it is not necessary for users of approved MPNs to also submit MPN applications. Claims administrators are required to report information on MPN use and payments to WCIS and if the Division needs a separate reporting of users of approved MPNs, that information can best be tracked and reported to the Division by the MPN applicants.*

*If the Administrative Director accepts this recommendation and inserts this subsection, the subsequent subsections will need to be renumbered.*

(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 six 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 of each physician listing. By submission of its provider listing, the applicant is affirming that all of the physicians listed **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.

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

*An individual or entity cannot attest to another’s “understanding.”*

(c)(3) The **voluntary** ancillary service provider file shall have only the following 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 (3) 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 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, **and have a current valid certification if required.**

*The ancillary service listing is voluntary as clarified in subdivision (d)(8)(I) and explained under the Specific Purpose heading for this section in the Initial Statement of Reasons.*

*It is not appropriate to include “specialty” in column 2). Ancillary service providers, other than those described as “physicians” in Labor Code section 3209.3, generally do not have specialties.*

*The requirement to affirm competence is overly broad. MPN applicants or their agents enter into contracts with ancillary providers with the good faith assumption that the provider is competent to provide such services. A requirement to affirm the license and certification requirement is sufficient.*

(c)(5) An MPN determines which locations are approved for providing treatment under the MPN, which are listed in its provider listing may limit the locations at which and/or affiliations under which providers may render services under the MPN by specifying those locations and/or affiliations in its listing. An MPN has the discretion to approve treatment at non-listed locations.

*The meaning of the proposed language is not clear. The modification is recommended for clarity.*

*In addition to service locations, an MPN must be able to limit affiliations under which providers may provide services. Some providers assert that once they have been accepted in an MPN under any affiliation, they are in the MPN for all affiliations. The addition is needed to ensure that an MPN may select a provider who participates in a medical group, but who also has a private practice, as participating in the MPN through their affiliation with the medical group and not through their private practice location.*

*This becomes an issue when large provider groups have agreements with individual providers who provide services at multiple locations, but only because of their affiliation with the large medical group. The MPN may be willing to allow the provider in the MPN because of the oversight provided by the large medical group, but because practice patterns change when treatment is through the private practice, the MPN does not want to include the private practice in the MPN. We are aware of several situations where injured employees are being asked to travel up to 230 miles by providers for treatment because the providers have office locations throughout the state, but will perform surgeries only near their home offices. We believe that this model creates additional risks and unnecessary inconvenience for injured employees.*

(d)(4) Name of Medical Provider Network. When submitting an application for a new MPN, Use a name that is not used by an existing approved Medical Provider Network. Use the name of the existing Medical Provider Network in an application for re-approval.

*These recommended modifications are suggested for clarity.*

(d)(8)(A) State the number of employees or injured employees expected to be covered by the MPN plan and the method used to calculate the number;

*Ultimately the number of network providers must be sufficient for the number of injured employees; however some applicants can more accurately estimate the number of employees than the number of injured employees. Allowing applicants to estimate either*

*the number of covered employees or the number of covered injured employees will provide the best estimates.*

*It is not necessary to describe the method used to calculate the number. This is necessarily an estimate.*

(d)(8)(C) The toll-free number, ~~email address, fax number~~ and days and times of availability to reach the MPN's medical access assistants.

*The statute does not require an email address and fax number. Because the statute delineates what is required (a toll-free telephone number and available days and hours), the additionally proposed requirements are an impermissible expansion of the Administrative Director's authority and the Institute recommends deleting the email address and fax number requirements, or clarifying that they are optional.*

(d)(8)(F) ~~Except for physicians who are a shareholder, partner, or employee of a medical group that elects to be part of the network, A~~affirm that each MPN physician ~~treating in the network or an authorized employee of the physician or physician's office provided a written acknowledgement that the physician elects has agreed in writing to be a member of treat workers under the MPN and that copies of the written acknowledgements with original signatures by each physician or an authorized employee of the physician or physician's office shall be in accordance with the requirements under "Physician Acknowledgments," section 9767.5.1, are available for review by or provided to the Administrative Director upon his or her request;~~

*This proposed requirement goes beyond what is required by Labor Code section 4616(a)(3). The recommended language conforms to that section. "Woods v Superior Court (1981) 28 Cal 3d 668; Mendoza v WCAB (2010) en banc opinion 75 CCC 634. See discussion under section 9767.1(a)(25)(C)."*

(d)(8)(G) A listing of the name, ~~specialty type~~, and location of each physician as described in Labor Code Section 3209.3, 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.

*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.*

(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 and may be 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-physician type.

*The Institute appreciates the revisions to the draft language that allow more flexibility in geocoding to document access compliance.*

*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.*

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

*Ancillary service providers, other than those described as “physicians” in Labor Code section 3209.3 generally do not have specialties, but the type of services they provide can be listed.*

*Ancillary service providers may provide goods as well as services. This is also consistent with the language in the definition of “ancillary services” in section 9767.1(a)(1).*

(d)(8)(J) Describe how the MPN arranges for providing ancillary services to its covered injured 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 for authorized services outside the MPN;

*It is more accurate to say that the MPN provides ancillary services to covered injured employees, and that referrals will be made outside the MPN if the services are authorized.*

(d)(8)(L) Describe how the MPN complies with the access standards set forth in section 9767.5 for all covered injured employees and state the five types of physicians most commonly used specialties for the to treat injured workers for the five most common injuries being covered under the MPN;

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

(d)(8)(M) Describe the employee notification process, and attach an English and Spanish copy of the required employee notification material Employee Notification, Independent Medical Review Employee Notification and Dependent Medical Review Application Form and information to be given to injured covered employees.

*When the MPN regulations were originally adopted there was confusion over what documents were actually required to be including in the application. "Information" is vague. Naming the specific documents that must be attached will avoid confusion and delays.*

(d)(8)(S) Describe the MPN's procedures used to ensure for ongoing review of its 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.

*The changes are recommended for clarity and accuracy and to align more closely with the requirements of Labor Code section 4616(b)(2). Because "sufficient" and "adequate" are vague and not defined elsewhere in California workers' compensation, the last phrase may cause confusion and dispute, and is therefore best deleted.*

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

1. Legal Name of MPN Applicant \_\_\_\_\_  
*"Legal" is not necessary here and because its intended meaning is not clear it will cause confusion and disputes. If the word remains, its intended meaning must be clarified.*

4. Eligibility Status of MPN Applicant

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

*Section 9767.1(13) includes CIGA and the State Compensation Insurance Fund, but not Self-Insurer Security Fund in the definition of "Insurer." See comments on MPN Applicant in section 9767.1(a)(19) regarding TPAs.*

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

(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 (b) and (c). An MPN shall meet the access standards for the five most commonly used specialties injuries listed in its application at all times.

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) 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**

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

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



(b) An MPN must have a primary treating care 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.

*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.”*

(c) An MPN must have a physician of each of the five most frequently used types described in Labor Code section 3209.3 to treat the five most common injuries providers of occupational health services and specialists 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).*

(d) 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.*

~~(d) If a 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 and 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 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.~~

(d) 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. 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.*

(e)(1) The MPN applicant shall have a written policy for arranging or approving non-emergency medical care for: (A) an injured 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.

*Clarification is needed that (A) applies to an injured covered employee.*

(e)(2) The written policy shall be for the claims administrator to provide the employees described in subdivision (e)(1) above with a list of at least three physicians outside the MPN geographic service area who either have been referred and properly reported by the injured 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.

*A list of three proposed physicians referred by the PTP can be sent only if reported.*

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

*Clarification is needed that (A) applies to an injured covered employee.*

(e)(5) Nothing in this section precludes an MPN applicant from having a written policy for an employee described in subdivision (e)(1) to choose his or her own provider or consult for non-emergency medical care.

*It is reasonable for an MPN applicant to have a written policy for an injured employee to choose a provider outside the network for treatment or consult.*

(h) MPN access assistants shall be located in the United States and available at a minimum from Monday through Saturday, from 7 am to 8 pm, Pacific Standard Time, 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.

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

~~(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.~~

*There is no statutory requirement for voice messaging, faxes or messages. This sub-section is not necessary.*

~~(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.~~

*This sub-section is also not necessary. It is not appropriate to mandate workflow, coordination or similar matters of internal administration.*

(i) If the primary treating physician refers the injured covered employee for approved treatment that cannot be provided by a physician within ~~to a type of specialist not included in the MPN the treatment may be permitted on a case-by-case basis by~~ covered employee may select a specialist from outside the MPN.

*Clarification is needed that this applies to an injured covered employee.*

*The changes are recommended to conform with Labor Code section 4616.3(d)(2) which requires that treatment by a specialist outside the MPN must be approved, and must be treatment that cannot be provided by a physician in the MPN. Labor Code section 4616.3(d)(2) says: “Treatment by a specialist who is not a member of the medical provider network may be permitted on a case-by-case basis if the medical provider network does not contain a physician who can provide the approved treatment and the approved treatment is approved by the employer or insurer.”*

## **Section 9767.5.1 Physician Acknowledgements**

(d) A single written group acknowledgment may be submitted for a medical group on behalf of all members of the medical group if an authorized employee of the medical group or his or her designee signs the acknowledgment and provides a copy to all members of the medical group. ~~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~~

acknowledgement 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. The medical group is required to submit updated rosters to the MPN to maintain MPN listings. Only providers that treat workers' compensation injuries are to be included on the roster listing. This amendment Modifications to roster listings shall be submitted to the MPN within ten days of the effective date of the change monthly, no later than the 5<sup>th</sup> business day of each month.

*The word "legal" is not necessary and because its intended meaning is not clear it will cause confusion and disputes. If the word remains, its intended meaning must be clarified.*

*9767.3(d)(8)(F), through its reference to 9767.5.1(d), is in conflict with 4616(a)(3). 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 code section continues on to state: "This paragraph does not apply to a physician who is a shareholder, partner, or employee of a medical group that elects to be part of the network." This sentence indicates that the affirmation from a medical group need only come from the medical group as a whole if the medical group is selected for participation in the MPN.*

*The requirement in 9767.5.1(d) conflicts with the statute by requiring "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." The requirement that each physician signs an acknowledgement for the medical group is a limitation that is not contained in the enabling statute, and is therefore void (Mendoza v WCAB (2010) En Banc Opinion 75 CCC 63). Additionally, it is administratively burdensome. The proper interpretation of section 4616(a)(3) is 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.*

*Because of the manner in which MPN listings are updated, we suggest that roster listings be submitted monthly to allow the MPN to update MPN listings in compliance with 9767.12(a)(2)(C) which requires deceased providers or providers no longer treating injured workers to be removed from the listing within 30 days (we are also recommending that this be modified to 90 days due to system update schedules and issues that will arise when an MPN is obtaining information from a leased network). This approach would be consistent with 4616((a)(4) which requires roster listings beginning January 1, 2014.*

*If it is the intent that the individual listing of a medical group that is included as a whole is all that is required, and that the network is not required to list each physician in the medical group in its filing or network listing, the Institute recommends that the Administrative Director add clarification to that effect. If this clarification is added, then the roster language proposed above is not applicable.*

## **Section 9767.6 Treatment and Change of Physicians Within MPN**

(a) When the injured covered employee notifies the employer, ~~or~~ insured employer ~~or claims administrator~~ of the injury or files a claim for workers' compensation with the employer, ~~or~~ insured employer ~~or claims administrator~~, the employer, ~~or~~ insured employer, ~~claims administrator~~ or entity that provides physician network services shall arrange an initial medical evaluation ~~and begin treatment~~ with an MPN physician in compliance with the access standards set forth in section 9767.5.

*Labor Code section 4616.3(a) required the employer to arrange an initial evaluation and begin treatment.*

*The other changes to the terms in (a), (b), (c), (d) and (e) are recommended for accuracy completeness and clarity.*

(b) Within one working day after an employee files a claim form under Labor Code section 5401, the ~~employer or insured employer~~ ~~claims administrator~~ shall provide for all treatment, consistent with guidelines adopted by the Administrative Director pursuant to Labor Code section 5307.27 and as set forth in title 8, California Code of Regulations, section 9792.20 et seq.

(c) The ~~employer or insurer~~ ~~claims administrator~~ shall provide for the treatment with MPN providers for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is rejected. Until the date the claim is rejected, liability for the claim shall be limited to ten thousand dollars (\$10,000).

(d) The employer, ~~or~~ insured employer, ~~claims administrator~~ 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 an MPN physician, the ~~injured~~ covered employee may select a physician of his or her choice from within the MPN. Selection by the covered ~~injured~~ 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~~ ~~claims administrator~~, after which the ~~injured~~ covered employee must select another treating physician in the MPN who is not a chiropractor.

*The recommended changes to "claims administrator" in (a), (b), (c), (d) and (e) are recommended for accuracy and clarity.*

*Clarification is needed that (e) applies to an injured covered employee.*

~~(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.~~

*There is no reason that a Petition for Change of Treating Physician should be prohibited for covered injured employees treating with MPN physicians. The Administrative Director does not have the authority to discriminate this way between treating physician*

*in the MPN and outside the MPN. The ability to petition provides protection for injured employees whether or not they are subject to an MPN.*

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

*The Institute suggests that the Division revise all the timeframes for filing changes to a standard 30 days from each change. When communications is necessary, as it often is, between an entity that provides MPN services, an MPN applicant, an MPN user, and/or an MPN provider, requiring changes to be filed prospectively, within 5 days, or within 15 days is impractical or impossible.*

(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 specified time frames or if no time frame is stated, then before any of the following changes occur:

(a)(2) Change in the eligibility status of the MPN Applicant. Filing required within fifteen (15) ~~five (5)~~ business days of knowledge of a change in eligibility.

*Although we understand the importance of an Applicant's eligibility status, 5 business days is an unreasonably aggressive standard and changing the timeframe to 15 business days is more reasonable.*

(a)(5) A change-decrease of 10% or more in the number or specialty type of providers participating in the network since the approval date of the previous MPN Plan application or modification. Filing required within thirty (30) business days of change.

*An increase in the number or type of providers will enhance, not jeopardize network accessibility and is therefore not a change that makes a modification and DWC review necessary. The Institute recommends confining the requirement to file an MPN Plan Modification to decreases of 10% or more. Requiring MPN applicants to file if the number of and type of providers increase will unnecessarily expend resources of MPN applicants and the Division alike.*

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

*Filing within 30 business days is more reasonable because the number of providers can change suddenly and significantly with little or no notice, for example, if a statewide chain of clinics suddenly opts in or out of a network.*

(a)(6) A change-An increase of 25% or more in the number of covered employees since the approval date of the previous MPN Plan application or modification. Filing required within (30) thirty business days of the change.

*A decrease in the number of covered employees will not jeopardize network accessibility and is therefore not a change that makes a modification and DWC review necessary. The Institute recommends confining the requirement to file an MPN Plan Modification to increases of 25% or more. Requiring MPN applicants to file if the number of covered*

*employees decreases by more than 25% will unnecessarily expend the resources of MPN applicants and the Division alike.*

*Filing within 30 business days is more reasonable because the number of covered employees can change suddenly and significantly without notice, for example as a result of a last-minute policy change decision by a large employer.*

(a)(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.

*Every network will add Medical Access Assistant information. Requiring every network to file a modification when complying with new law is overkill and will expend resources unnecessarily.*

(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, 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 section 9767.14 and/or 9767.19.~~

*The submission requirement regarding a change of DWC liaison or authorized individual is not necessary in this subsection because it is addressed in (a)(3).*

*The submission requirement regarding a change of eligibility status is also not necessary in this subsection because it is addressed in (a)(2).*

*The warning regarding potential administrative actions is unnecessary as they are addressed in associated MPN sections.*

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

For DWC only: MPN Approval Number	Date Notice Received: / /
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<b>Notice of Medical Provider Network Plan Modification §9767.8</b>
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1. ~~Legal~~ Name of MPN Applicant \_\_\_\_\_

*Adding “Legal” is not necessary and because its intended meaning is not clear it will cause confusion and disputes. If the word remains, its intended meaning must be clarified.*

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

\_\_\_\_\_ ☐ Self-Insured Employer

☐ Insurer ~~(including CIGA, State Fund)~~ ☐ Group of Self-Insured Employers



☐ Self-Insured Security Fund      ☐ Joint Powers Authority      ☐ State      ☐ TPA

☐ Entity that provides physician network services

*If the DWC already has this information pursuant to the original application process, the Institute recommends deleting 5 because it is not necessary.*

*If it does not, the recommended changes make the Notice Modification consistent with the MPN application cover and the regulations.*

*State Compensation Insurance Fund, not the Self-Insured Security Fund, is included in the definition of Insurer. See comments on MPN Applicant in section 9767.1(a)(19) regarding TPAs.*

**6. Dates of last plan modifications approval:**

*Since the DWC already has this information the Institute recommends deleting 6 because it is unnecessary.*

**8. Authorized Liaison to DWC:**

Name	Title	Organization
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Phone	Email
-------	-------

Address	Fax number
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*Since the DWC also already has this information the Institute recommends deleting 8 because it is unnecessary.*

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.

☐ 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)~~ fifteen (15) business days of change in status.



*Although we understand the importance of an Applicant's eligibility status, 5 business days is an unreasonably aggressive standard and changing the timeframe to 15 business days is more reasonable.*

- ☐ 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 Decrease** of 10% or more in the number or **specialty type** 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. **Filing required within (30) thirty business days of the change.**

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

*As previously noted, filing within 30 business days is more reasonable because the number of providers can change suddenly and significantly with little or no notice, if, for example, a statewide chain of clinics suddenly opts in or out of a network.*

- ☐ **Change Increase** of 25% or more in the number of covered employees since the approval date of the previous MPN Plan application or modification. **Filing required within (30) thirty business days of the change.**

*Filing within 30 business days is more reasonable because the number of covered employees can change suddenly and significantly without notice, for example as a result of a last minute policy change decision by a large employer.*

- ☐ 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.

*Note: Unless the AD specifies exceptions such as for changes to comply with statutory or regulatory changes, every MPN must submit a Plan Modification and copies of revised notification materials. We suggest the Administrative Director consider exempting changes made to comply with statutory or regulatory timeframes or adjusting the submission timeframes for these changes.*

☐ Change in use of one of the following Deemed Entities: Health Care Organization (HCO), Health Care Service Plan, Group Disability Insurer, or Taft-Hartley Health and Welfare Trust Fund.

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

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

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

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

Submit 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.

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

(a) At the time of the injury is reported 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 injured covered employee by the employer, insurer, claims administrator or an entity that provides physician network services. This MPN notification shall be provided in English and also in Spanish if the employee primarily speaks Spanish and does not proficiently speak or understand the English language.

*The injury is not always reported when it occurs.*

*Clarification that the notification is for an injured covered employee is suggested.*

*The claims administrator may also provide the notification.*

*The notice in Spanish is only necessary if the employee does not proficiently speak or understand the English language.*

(a)(2)(C) How to review, receive or access the MPN provider directory. An employer, insurer, claims administrator 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, or by mutual agreement, by email. 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. 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. The Unless the participating provider is contractually obligated to provide notification of any change in the listing information, the MPN shall contact participating providers on a quarterly basis annually to ensure the listing information for the provider and/or medical group is 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 30-90 days of notice to the MPN Contact.

*If the employee requests an electronic listing, providing it by email should be an option if mutually agreed upon.*

*If a participating provider is contractually obligated to provide notification of any change in the listing, it is not necessary to also contact him or her to ensure the listing information for the provider and/or medical group is accurate. It is not possible to contact all participating providers quarterly, particularly for large networks. It will be difficult and costly to do so even annually. As currently proposed, participating providers will also be negatively affected because they will be subject to hundreds of telephone calls quarterly. This is impractical and unnecessary. Other medical networks, including group health networks and disability networks, are not burdened with such unreasonable requirements. It is not necessary to single out MPN networks with this burden, nor is it necessary to burden employers with the additional expense it will cause.*

*It is not as easy and quick to remove a provider as one might at first expect. For example, just because the MPN Contact receives a telephone call claiming that a listed provider is deceased or is no longer treating workers' compensation patients at the listed address does not mean the name can be immediately removed from the listing. First the telephone claim must be verified and facts documented. Contract issues and procedures may be triggered and then must be addressed. Every unscheduled update is very costly and requires significant resources and time to achieve. A minimum of 45 days is generally necessary, barring complications. It is therefore unreasonable to require provider listings to be current within 30 days, and 60 days is often insufficient. 90 days is more reasonable.*

(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 unless the injured employee must continue to receive treatment under that MPN. The notice required by this section shall be provided in English and also in Spanish if the employee speaks Spanish and does not proficiently speak or understand the English language.

*No notice is necessary if the injured employee must continue to receive treatment under the MPN. Receiving a notice that does not affect him or her will serve only to confuse the employee and add to administrative expenses, and adds a potential penalty for failing to do something that was unnecessary in the first place.*

*The notice in Spanish is only necessary if the employee does not proficiently speak or understand the English language.*

(b)(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, MPN Email Address(es), and MPN Website."

*It is not necessary to include information on new injuries in the notice as the employee will receive a separate notice at the time of a new injury.*

*No notice is necessary if the injured employee must continue to receive medical treatment under the MPN. It will only serve to confuse the injured employee to receive an unnecessary notice. The administrative expense for a required but useless notice is also unnecessary.*

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

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

*See comment on section 9767.3(d)(8)(H).*

## **Section 9767.16.5 DWC MPN Complaint Form [see attached]**

***See also the comment under the Forms heading at the end of these Forum comments.***

If the MPN fails to remedy the violation within 30 calendar days from the date the complaint was made to the MPN, the complainant can file a written complaint with the DWC by:

1. Using the DWC Complaint form;
2. Attaching "documentary evidence that the MPN has been notified" of the violation;
- and
3. Serving a copy of the complaint on the MPN

*The Institute recommends that the Division add this information to the DWC Complaint form. While this information is in the draft regulation, it is not currently included on the form and will be overlooked, particularly by injured employees who are not conversant with the detailed content of regulations.*

☐ Other: \_\_\_\_\_

*A prompt is necessary to identify the role of the person filing the complaint.*

## Section 9767.17 Petition to Suspend or Revoke 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:

(a)(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 of the five types of physician most commonly used to treat the five most common injuries listed in the MPN application commonly used specialty listed in the MPN application in at least fifteen (15) percent of the two specific locations within the MPN geographic service area described in the MPN geographic service area described in the MPN plan unless the injured employee is authorized to go outside the network.

*See the comment on sections 9767.1(a)(25) and 9767.5(a) through (d).*

*Two specific locations in an MPN with a small geographic service area is a very different standard than for two specific locations in an MPN with a statewide geographic service area. The standard will be unfair and invalid unless proportionately determined.*

*No violation should be found if the injured employee is authorized to go outside the network.*

## Section 9767.17.5 DWC Petition to Suspend or Revoke an MPN Form [see attached]

*See also the comment under the Forms heading at the end of these comments.*

MPN APPROVAL LOG NO:

*The log number is not necessary.*

THE MPN HAS FAILED TO MEET ACCESS STANDARDS FOR COMMONLY USED SPECIALTY(IES) PHYSICIAN TYPES LISTED IN THE APPLICATION IN THE FOLLOWING LOCATIONS OR SPECIALTIES IN THE MPN GEOGRAPHIC SERVICE AREA:

LOCATION: \_\_\_\_\_ SPECIALTY PHYSICIAN TYPE: \_\_\_\_\_

LOCATION: \_\_\_\_\_ SPECIALTY PHYSICIAN TYPE: \_\_\_\_\_

LOCATION: \_\_\_\_\_ SPECIALTY PHYSICIAN TYPE: \_\_\_\_\_

*See previous comments on sections 9767.1(a)(25)(C).*

## Section 9767.18 Random Reviews

(a)(2)(B)(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.

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

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

## **Section 9767.19 Administrative Penalty Schedule; Hearing**

*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.*



(a)(1)(B) Failure to file an original Notice of MPN Plan Modification within ~~five (5)~~ fifteen (15) business days of a change in the MPN applicant's eligibility status, \$2,500.

*See comment on section 9767.8(a)(2).*

(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.

*See all comments under 9767.12.*

(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.

*See all comments under 9767.12.*

(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.

*See all comments under 9767.12(b) and 9767.12 (b)(2).*

(a)(3)(A) Failure to perform at least quarterly updates ~~to confirm the accuracy~~ of the ~~medical~~ ~~physician~~ and ancillary provider listings, for each ~~inaccurate entry~~ ~~failure to update at least~~ ~~quarterly~~, \$250, up to a total of \$10,000 per quarter.

*This penalty applies when the medical and ancillary provider listings are not updated on a quarterly basis. An inaccurate listing may be the result of something other than timely updates.*

(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.

*See comments on section 9767.12(a)(2)(C).*

(a)(3)(C) Failure to meet the access standards ~~if treatment was not allowed outside the MPN~~, 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.

*See comments under section 9767.5.*

*No access standard penalty should apply if treatment is allowed outside the MPN when the standard is unmet.*



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

*LC section 4616(a)(2) specifies that medical treatment for injuries must be readily available at reasonable times and accessible to the extent feasible. Circumstances sometimes arise that make a non-emergency initial appointment within 3 business days infeasible.*

(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.

*See comments under section 9767.5.*

## **Forms**

The three separate draft forms provided for the DWC Forum are in PDF format only, and we therefore cannot display all the revisions we recommend on the draft formats. The Institute recommends that the Administrative Director revise the forms to conform to the changes recommended in these Forum comments.

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