



California Workers' Compensation Institute

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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 2nd 15-Day Comment - Additional 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, Fireman's Fund Insurance Company, The Hartford, ICW Group, Liberty Mutual Insurance, Pacific Compensation Insurance Company, Preferred Employers Group, 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

The latest version of the Administrative Director's proposed MPN regulations continues to require that networks adhere to the "specialists standards" under threat of severe administrative penalties. By requiring that MPNs be composed of "physician specialists" rather than "types of physicians," the statutory standard, the Administrative Director (AD) has created an untenable and unworkable regulatory scheme. Simply stated, in any given area there are many more generalists than there are specialists. Basing network staffing standards on specialists alters the ability of networks to function as the Legislature intended. The standards are enforced with additional, administrative penalties, which impose significant potential liability on MPNs and impermissibly impede network operations.

Authority

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

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 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 basic problem is that the threat of excessive access standards and penalties will curtail legitimate network operations that the statute permits.

While it is the responsibility of the 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. When the language is clear and there is no uncertainty as to the legislative intent, the regulator must simply enforce the statute according to its terms." DuBois v. WCAB (1993) 5 Cal.4th 382, 387, 58 Cal.Comp.Cases 286, Atlantic Richfield Co. v. WCAB (Arvizu) (1982) 31 Cal.3d 715, 726, 47 Cal. Comp. Cases 500.

Throughout the proposed MPN regulations, the DWC refers to the physicians within the MPN as "specialists" and sets the access standards based on physician specialists (Section 9767.5 Access Standards), but Labor Code section 4616(a)(1) could not be more clear:

... The network shall include physicians primarily engaged in the treatment of occupational injuries. ...The number of physicians in the medical provider network shall be sufficient to enable treatment for injuries or conditions to be provided in a timely manner. 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 (emphasis added).

Labor Code section 3209.3 specifies:

(a) "Physician" includes physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.

(b) "Psychologist" means a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology. ...

(d) "Acupuncturist" means a person who holds an acupuncturist's certificate issued pursuant to Chapter 12 (commencing with Section 4925) of Division 2 of the Business and Professions Code.

By referring specifically to the statutory definition of physician, the Legislature unmistakably and expressly mandated that the networks contain "an adequate number and type of physicians" to treat common injuries experienced by injured employees.

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.

Access Standards

Labor Code section 4616(a)(2) directs the Administrative Director to consider the needs of areas in which health facilities are at least thirty miles apart. As currently written, the Administrative Director's access standard for primary treating physicians, hospitals and providers of emergency health care services in Section 9767.5 is 15 miles or 30 minutes.

According to Health and Safety Code section 1250, a "health facility" is any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness. This means that offices of primary treating physicians, hospitals, providers of emergency health and clinics are all health facilities.

In MPN areas where health facilities are at least fifteen miles apart the MPN will often be unable to meet the existing MPN access standards of three primary treating physicians within fifteen miles, yet pursuant to Labor Code section 4616(a)(2), the Administrative Director is directed to consider the needs where health facilities are at least thirty miles apart. The Institute believes that the MPN access standards for these physicians and health facilities should be set at 30 miles and 60 minutes instead of 15 miles and 30 minutes so that they are consistent with the thirty-mile benchmark set by statute. This will harmonize the statute and regulations and make it easier for MPN to offer alternative standards on the occasions they are needed when health care facilities are more than thirty miles apart and there is a shortage of providers.

Penalties

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.

Discussion

The Institute's prior comments and recommendations below are intended to provide the flexibility necessary to allow medical networks to provide injured workers with the best medical care as promptly as possible, within or outside the network. Recommended specific modifications are indicated by underline and ~~strikethrough~~, and discussion by *italics*.

Regulations

Section 9767.1 Medical Provider Networks – Definitions:

(a)(12) "Health care shortage" means a situation in a geographical area in which the number of physicians in of a particular specialty type described in Labor Code section 3209.3, necessary to treat common injuries experienced by injured employees who are available and willing to treat injured workers under the California workers' compensation system is insufficient to meet the Medical Provider Network access standards set forth in 9767.5(a) through (c) to ensure medical treatment is available and accessible at reasonable times. A lack of physicians participating in an MPN does not constitute a health care shortage where a sufficient number of physicians in of that specialty type are available within the access standards and willing to treat injured workers under the California workers' compensation system.

Discussion

Here and elsewhere in these regulations the Administrative Director has defined “physician type” to mean “specialty,” even though the statute specifically defines physician type by reference to sections 3209.3. 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. See comments on Section 9767.5(a) for additional discussion.

(16) “Medical Provider Network Medical Access Assistant” means an individual in the United States provided by **the claims administrator or** Medical Provider Network to help injured workers with finding available Medical Provider Network physicians of the injured workers’ choice and with scheduling provider appointments. **An access assistant may not authorize payment of goods or services unless she or he is a certified adjuster.**

Discussion

A claims administrator may also provide an individual to help injured employees find and schedule appointments with available MPN physicians.

The recommended modification clarifies that a medical access assistant may not authorize payment for goods or services if she or he is not a certified adjuster. It is important that physicians understand that an appointment set by an access assistant does not imply authorization for payment.

(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.

Discussion

Here and elsewhere in these regulations the Administrative Director has defined “physician type” to mean “specialty,” even though the statute specifically defines physician type by reference to sections 3209.3. 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. See comments on Section 9767.5(a) for additional discussion.

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 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 18161st day for a period of four years.

Discussion

It is not necessary for the Administrative Director to allow six months for a review of a complete plan for MPN approval. Sixty 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 from three to six months for approval may be outdated or obsolete before it is approved.

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

Discussion

Without this change it will not be clear that the Identification number will be assigned by the DWC to the MPN upon approval.

Section 9767.3 Requirements for a Medical Provider Network Plan

(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.

Discussion

The necessity for the newly proposed “provider codes” in the second sentence is not clear. The physician’s specialty must already be submitted in one column. No reason for the codes has been given and none is evident. No definitions are provided for the code names except for “occupational medicine” which means “the diagnosis or treatment of any injury or disease arising out of and in the course of employment,” which surely is what every physician in the network is providing. “Occupational therapy medicine,” on the other hand, is

a mystery. If these codes are meant to identify the type of physicians the Division believes generally treat common injuries experienced by injured employees as referenced in Labor Code section 4616(a), these regulations must define them and clarify their use in lieu specialties. If not, the Institute recommends deleting them because they unnecessary.

See the comment on physician type versus physician specialty in Section 9767.5(a).

(c)(3) If an MPN chooses to provide ancillary services, the 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 within California. By submission of an ancillary provider listing, the applicant is affirming that the providers listed can provide the requested medical services or goods and have a current valid license number or certification to practice, if they are required to have a license or certification by the State of California. If interpreter services are included as an MPN ancillary service, the interpreters listed must be **certified qualified** pursuant to section 9795.1.6(a)(2)(A), **and** (B), **or** (C).

Discussion

Delete the newly added last sentence. If the Administrative Director does not delete the sentence, modify it as indicated.

- LC 4600(f) requires the use of a qualified interpreter when an employee who does not proficiently speak or understand English submits to examination at the request of the employer, insurer, the administrative director, appeals board or judge. In these circumstances a qualified interpreter must have been certified by the State Personnel Board as a court or administrative hearing interpreter, be on the DWC Administrative Director's updated list of certified administrative hearing or medical examination interpreters, or be a certified court interpreter per the Judicial Council or State Personnel Board.
- LC 4600(g) requires the use of a qualified interpreter during medical treatment appointments if the injured employee cannot effectively communicate with his or her treating physician because he or she cannot proficiently speak or understand the English language. However, to be a qualified interpreter for purposes of medical treatment appointments, an interpreter is specifically not required to meet the requirements of subdivision LC 4600(f),* (i.e., is not required to be a certified interpreter) but must meet any requirements established by rule by the Administrative Director that are substantially similar to the requirements set forth in Health and Safety Code section 1367.04.** This section also requires the Administrative Director to adopt a fee schedule for qualified interpreter fees in accordance with this section and requires the employer or insurance carrier to pay for interpreter services upon request of the injured employee, but does not require the employer to pay for the services of an interpreter who is not certified or an interpreter who is provisionally certified by the provider unless either the employer consents in advance to the selection of the individual interpreter, or the language is other than the languages designated pursuant to Government Code section 11435.40.

(f)*includes interpreters certified by State Personnel Board as court or administrative hearing interpreters, and the DWC Administrative Director's updated list of certified administrative hearing and medical examination interpreters; and Judicial Council or State Personnel Board certified court interpreters.

1367.04**requirements for health care service plans – no requirement for certified interpreters.

Since MPNs are used for medical treatment, and the statute specifically says qualified interpreters for medical treatment appointments are not required to be certified, a regulation that limits MPN interpreters to certified interpreters is contrary to the statute. 9795.1.6(a)(2)(A) and (B) are requirements pursuant to Labor Code section LC 4600(f) whereas 9795.1.6(a)(2)(C) relates to qualified interpreter standards for medical treatment appointments pursuant to LC 4600(g). The Institute believes the Administrative Director does not have authority to prohibit the inclusion of qualified interpreters, who may be non-certified, in an MPN for medical treatment appointments, nor their payment at contracted rates.

(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.

Discussion

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.

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

Discussion

The additional requirement is not necessary. If it is not deleted it will be necessary to clarify what license, certification or other proof of MPN eligibility must be supplied by a managed care entity, CIGA, State Fund, SISF and the State because otherwise it is not clear what is available or sufficient as proof for these entities.

(d)(8)(E) State the web address or URL to the roster of all treating physicians in the MPN. Affirm that the roster of all treating physicians in the MPN shall indicate if a physician is not currently taking new workers' compensation patients and affirm that secondary treating

physicians who can only be seen with an approved referral are clearly designated “by referral only”.

Discussion

Since the status of whether a physician is currently taking new workers’ compensation patients changes frequently (sometimes daily) and can change unexpectedly at any time, and since the roster cannot be instantly changed, the MPN applicant cannot “affirm that the roster of all treating physicians in an MPN indicate if a physician is not currently taking new workers’ compensation patients.” It is also not appropriate to require physicians to be indicated on the roster as “secondary treating physicians” who are seen “by referral only” since those same physicians may also serve as primary treating physicians and/or the “by referral” may depend on the type of service being sought or other circumstances. The legislature required no such complexity and such additional requirements will foster yet more disputes and litigation. Instead, the medical access assistant position was created by the legislature in Senate Bill 863 to assist the injured employee with finding and securing appointments with appropriate and available physicians.

(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 each medical group or subgroup of a larger medical group that includes every physician in the group or subgroup 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.

Discussion

As also suggested in (c)(4), the 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. If an entire medical group or subgroup of a medical group is contracted to provide occupational medicine services under the plan, it is not necessary to list the individual physicians.

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.

(d)(8)(H) Provide an electronic copy in Microsoft Excel format of the geocoding results of the MPN provider directory to show estimated compliance with the access standards set forth in section 9767.5. The access standards set forth in section 9767.5 are determined by the injured employee's residence or workplace address and not the center of a zip code. The geocoding results will be used by DWC in reviewing MPN plans to give an approximation of MPN compliance with the access standards set forth in section 9767.5. The geocoding results shall include the following separate files summarizing data reasonably available at the time of compilation: 1) a complete list of all zip codes within the MPN geographic service area; 2) a narrative or graphic report that establishes where there are at least three available primary ~~treating care~~ physicians within the ~~fifteen-thirty~~-mile access standard from the center of each zip code within the MPN geographic service area; 3) a narrative or graphic report that establishes where there is a hospital or an emergency health care service provider within ~~the fifteen-mile access standard from the center of~~ each zip code within the MPN geographic service area; 4) a narrative or graphic report that establishes where there are at least three available ~~types of~~ physicians ~~described in Labor Code section 3209.3 in each of the specialties~~ commonly required to treat injured workers covered by the MPN within the thirty-mile access standard from the center of each zip code within the MPN geographic service area; 5) a list of all zip codes where access standards are not met for primary ~~treating care~~ physicians, ~~for acute care hospitals or emergency facilities, and for each specialty listed to treat common injuries experienced by injured workers covered by the MPN,~~ and a narrative report explaining if medical treatment will be provided according to an approved alternative access standard or according to a written policy permitting out of MPN treatment in those areas; ~~and 6) each physician listed in the MPN provider directory listing shall be assigned at least one provider code as set forth in subdivision (e)(2) of this section to be used in the geocoding reports.~~

Discussion

The Institute appreciates the clarification that while access standards are measured from the employee's residence or workplace address, geocoding results that measure distance from the center of a zip code are to show estimated compliance with the access standards.

Labor Code section 4616(a)(2) directs the Administrative Director to consider the needs of areas in which health facilities are at least thirty miles apart. According to Health and Safety Code section 1250, a "health facility" is any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness. The Institute believes Labor Code section 4616(a)(1) and section (b) of this section that implements it, and the MPN access standards in (a) of this section must harmonize. It is therefore necessary to revise the MPN access standards to reflect a thirty mile distance standard for health care facilities. In areas of MPNs where health facilities are at least fifteen miles apart the MPN will often be unable to meet the existing MPN access standards, yet pursuant to Labor Code section 4616(a)(2), the Administrative Director is only directed to consider the needs where health facilities are at least thirty miles apart. It is reasonable and necessary to tie both to a thirty mile standard so that the MPN can offer alternative standards when they are needed.

See in addition the comments on section 9767.5(a) regarding physician type versus physician specialty.

See also the comment on section (c)(2). There is no apparent purpose for the newly proposed provider codes for this section as well and they are therefore unnecessary.

Section 9767.5 Access Standards

(a) An MPN must have at least three ~~available~~ physicians of each ~~specialty type necessary~~ 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).

(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 ~~360~~ minutes or ~~15~~ ~~30~~ miles of each covered employee's residence or workplace, ~~and must include hospitals for emergency health care services, and/or providers separate from such hospitals of all emergency health care services.~~

(a)(2) An MPN must ~~have include providers of occupational health services and specialists the types of physicians described in Labor Code section 3209.3~~ 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, ~~and physicians primarily engaged in the treatment of occupational injuries.~~

Discussion

Labor Code section 4616(a)(2) directs the Administrative Director to consider the needs of areas in which health facilities are at least thirty miles apart. According to Health and Safety Code section 1250, a "health facility" is any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness. The Institute believes Labor Code section 4616(a)(1) and section (b) of this section that implements it, and the MPN access standards in (a) of this section must harmonize. It is therefore necessary to revise the MPN access standards to reflect a thirty mile distance standard for health care facilities. In areas of MPNs where health facilities are at least fifteen miles apart the MPN will often be unable to meet the existing MPN access standards, yet pursuant to Labor Code section 4616(a)(2), the Administrative Director is only directed to consider the needs where health facilities are at least thirty miles apart. It is reasonable and necessary, as well as consistent to tie both to a thirty mile standard so that the MPN can offer alternative standards when they are needed.

We note that 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. While 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.”**

It is still 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.”

Labor Code section 4616(a)(1) requires a sufficient number of physicians of the types described in Labor Code section 3902.3, not of specialists, nor of providers of

occupational health services. In addition, it simply requires the network to “include physicians primarily engaged in the treatment of occupational injuries.” The Institute believes the Administrative Director does not have authority to expand this statutory requirement.

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 CCR, Title 10, section 2240(k) of the Insurance Commissioner’s regulations on Network Access Standards:

(k) "Primary care physician" means 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 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.”**

(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.

Discussion

The Institute points out that there is no statutory requirement to provide a Spanish-speaking MPN access assistant. Interpreter services can be provided if needed.

~~(h)(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.~~

Discussion

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

~~(h)(2) MPN medical access assistants have different duties than claims adjusters. A medical access assistant who is not an adjuster may not authorize medical treatment. MPN medical access assistants work in coordination with the MPN Contact and the claims adjuster(s) to ensure timely and appropriate medical treatment is provided to the injured worker. Although their duties are different, if the same person performs both, the Contacts by MPN medical access assistant's who are not adjusters ~~contacts~~ must be separately and accurately logged documented.~~

Discussion

Specific language is necessary to clarify that an access assistant who is not an adjuster may not authorize medical goods or services. This clarification will prevent the disputes that will otherwise occur.

Claims adjusters already document their contacts in the claims file and should not be required to document them again. It is not appropriate to mandate workflow, coordination or similar matters of internal administration. There is no statutory requirement for logging contacts and the term “logged” is not clear and not necessary. The Institute recommends replacing the term “logged” with “documented.” If a requirement to “log” is retained, require contacts to be “logged” only by medical access assistants who are not adjusters.

Section 9767.5.1 Physician Acknowledgements

~~(a) An MPN applicant or network contracting agent shall obtain from each physician participating in the at the time of entering into or renewing the MPN agreement, commencing on [OAL to insert effective date of regulations] ~~MPN~~ a written acknowledgment in which the physician affirmatively elects to be a member of the MPN as provided in this section. This section does not apply to a physician who is a shareholder, partner, or employee of a medical group that elects to participate in the MPN, however this section applies to the medical group that elects to participate in the MPN.~~

Discussion

Specify in this section that the written acknowledgement is required at the time of entering into or renewing a network agreement, to conform with Labor Code section 4616(a)(3), which says that, commencing January 1, 2014, a treating physician shall be included in the

network only if the physician/authorized employee affirmatively elects to be a network member in writing at the time of entering into or renewing a network agreement.

If the subdivision is restricted to contracting physicians, the medical group reference is not applicable.

(b) The following persons may execute the acknowledgment:

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

(b)(1)(A) ~~By t~~The physician(s); or

(b)(1)(B) ~~By a~~An employee of the physician or an employee of the physician's office; or

(b)(1)(C) If authorized by the physician(s), ~~by~~ an agent or representative of a medical group.

(b)(1)(D) Pursuant to written contractual agreement.

Discussion

An alternative method agreed to in writing will provide more flexibility and opportunities for more efficiency.

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

(e)(1) If, on or after [OAL to insert effective date of regulations], the physician or medical group enters into a new contract or renews a contract to participate in the MPN, then the acknowledgment shall be obtained at the time of entering into or renewing the contract.

~~(e)(2) If, on or after [OAL to insert effective date of regulations], the physician joins a medical group that already has a contract to participate in an MPN or MPNs, the acknowledgment shall be obtained at the time of the physician's joining the medical group.~~

(e)(3) If, on or after January 1, 2014 but before [OAL to insert effective date of regulations], the physician or medical group enters into a new contract or renews a contract to participate in the MPN, then the acknowledgment shall be obtained no later than January 1, 2015.

~~(e)(4) If, on or after January 1, 2014 but before [OAL to insert effective date of regulations], the physician joins a medical group that already has a contract to participate in an MPN or MPNs, the acknowledgment shall be obtained no later than January 1, 2015.~~

(e)(5) If a contract entered prior to [OAL to insert effective date of regulations] is continuous or automatically renews without a new execution by or on behalf of the physician, then ~~the acknowledgment shall be obtained no later than January 1, 2016, provided, however that no~~ further acknowledgment is required if either of the following is true:

(e)(5)(A) The contract identifies the MPN in which the physician or group is participating.

(e)(5)(B) A website address is openly published where a person described in subdivision (b) is enabled to observe which MPN or MPNs~~ss~~ have been selected for the physician or group and to de-select any MPN. The means to authenticate a person to access the website and to de-select any MPN shall be made available upon reasonable proof of the requesting person's identity as one of the persons authorized in subdivision (b).

Discussion

Per Labor Code section 4616(a)(3), commencing January 1, 2014, a treating physician shall be included in the network only if the physician/authorized employee affirmatively elects to be a network member in writing at the time of entering into or renewing a network agreement. The Labor Code specifically states the circumstances under which the acknowledgement is required and the Administrative Director has no authority to expand them. If a physician or group is already under contract, an acknowledgement is required only at the time of renewing the network agreement.

The change suggested in (e)(5)(B) will correct a minor typographical error.

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

Discussion

The physician acknowledgement should be secured by the contracting entity. The acknowledgement can be obtained at the time of entering into or renewing a contract. Mandating additional acknowledgements places an unnecessary burden on physicians and MPN applicants.

Section 9767.12 Employee Notification.

(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 geographic service area includes more than one area code. A toll-free number must also be listed for MPN Medical Access Assistants, with a description of the access assistance they provide, including finding available 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;

Discussion

Physician offices confirm appointments with patients. The physician's office needs to know whether to expect the employee on the scheduled day, or to reschedule it and make that slot available for another patient. If the medical access assistant also contacts the employee to confirm an appointment, there will be potential for miscommunication and confusion. Requiring medical access assistants to confirm appointments is not necessary and is not supported by statute.

Section 9767.15 Compliance with Current MPN Regulations; Reapproval

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

Discussion

See comments on Section 9767.5(a) regarding primary care physicians, a thirty-mile access standard, physician type verses specialty, hospitals and emergency facilities access standards; and see comments on Section 9767.3(c)(2) regarding provider codes.

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 one occasion in at least two specific access locations within the MPN geographic service area. Additionally, the MPN failed to ensure in each instance that a worker received necessary medical treatment within the MPN ~~or and~~ failed to authorize treatment outside of the MPN within the required time frames and access standards.

Discussion

This suggested change corrects what appears to be an inadvertent typographical error, as there is no violation unless the MPN failed to provide necessary treatment within the MPN and also failed to authorize that treatment outside the MPN.

Section 9767.18 Random Reviews

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

Discussion

See comments on Section 9767.5(h)(2). Also there is no such requirement for the MPN Contact.

Section 9767.19 Administrative Penalty Schedule; Hearing, Mitigation and Appeal

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

Discussion

Since penalties and other consequences are new, time will be needed to revise work-flows, to educate staff and other entities, and to roll out changes, violations must be considered on a going-forward basis, allowing a minimum of six months for implementation prior to assessing penalties and other consequences.

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

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

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

Discussion

Subsection (1) is unnecessary as it is duplicative of (2).

(b)(3) Failure to provide an injured covered employee who is still treating under an MPN written notice of the date the employee will no longer be able to use the MPN, \$250 \$1,000 per occurrence.

Discussion

\$1,000 is excessive. \$250 is more reasonable, particularly since the injured employee continues to receive treatment.

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 John Cortes
CWCI Claims Committee
CWCI Medical Care Committee
CWCI Legal Committee
CWCI Regular Members
CWCI Associate Members