TITLE 8. Industrial Relations

Division 1. Department of Industrial Relations

Chapter 4.5. Division of Workers' Compensation

Subchapter 1. Administrative Director--Administrative Rules

ARTICLE 3.5 Medical Provider Network

Section 9767.1 Medical Provider Networks – Definitions:

(a) As used in this article:

(1) "Ancillary services" means non-physician medical provider services, which may include, but is not limited to, hospitals, laboratories, physical therapists, and pharmacies.

(2) "Applicant" means an insurer or employer as defined in subdivisions (6) and (10) of this section.

(3) "Covered employee" means an employee whose employer has established a Medical Provider Network for the provision of medical treatment to injured employees.

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

(5) "Economic profiling" shall mean any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.

(6) "Employer" means a self-insured employer, joint powers authority, or the state.

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

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

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

(10) "Insurer" means an insurer admitted to transact workers' compensation insurance in the state of California, or the State Compensation Insurance Fund.

(11) “Medical Provider Network” means any entity or group of providers approved as a Medical Provider Network (MPN) by the Administrative Director pursuant to Labor Code sections 4616 to 4616.7 and this article.

(12) “Medical Provider Network Plan” means the detailed proposal for a medical provider network contained in an application submitted to the Administrative Director by an applicant.

(13) “Nonoccupational Medicine” means the diagnosis and treatment of any injury or disease not arising out of and in the course of employment.

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

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

(16) “Primary care physician” means a physician within a medical provider network designated by the applicant to treat injured employees.

(17) “Primary treating physician” means a primary treating physician within the applicant’s medical provider network and as defined by section 9785(a)(1)

(18) “Provider” means a physician as described in Labor Code section 3209.3 or other provider as described in Labor Code section 3209.5

(19) “Second Opinion” means an opinion rendered by a medical provider network physician to address an employee’s dispute over either the diagnosis or the treatment prescribed by the treating physician.

(20) “Taft-Hartley health and welfare fund” means an entity designated pursuant to Labor Code section 4616.7(d).

(21) “Third Opinion” means an opinion rendered by a medical provider network physician to address an employee’s dispute over either the diagnosis or the treatment prescribed by either the treating physician or physician rendering the second opinion.

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

Reference: Sections 3208, 3209.3, 3209.5, 3702, 4616, 4616.1, 4616.3, 4616.5 and 4616.7, Labor Code.

Section 9767.2 Review of Medical Provider Network Application

(a) Within 60 days of the Administrative Director's receipt of a complete application, the Administrative Director shall approve or disapprove an application based on the requirements of Labor Code section 4616 et seq. and this article. An application shall be considered complete if it includes information responsive to each applicable subdivision of section 9767.3. Pursuant to Labor Code section 4616(b), if the Administrative Director has not acted on a plan within 60 days of submittal of a complete plan, it shall be deemed approved.

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

(c) Upon approval of the Medical Provider Network Plan, the Medical Provider Network will be assigned a MPN approval number.

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

Reference: Section 4616, Labor Code.

Section 9767.3 Application for a Medical Provider Network

(a) As long as the application for a medical provider network meets the requirements of Labor Code section 4616 et seq. and this article, nothing in this section precludes an employer or insurer from submitting for approval one or more medical provider networks in its application.

(b) Nothing in this section precludes an insurer and a policyholder or prospective policyholder, or an insurer and an employer seeking to purchase a policy of insurance, from agreeing to submitting for approval a medical provider network which meets the specific needs of an employer considering the experience of the employer, the common injuries experienced by the employer, the type of occupation and industry in which the employer is engaged and the geographic area where the employees are employed.

(c) All applicants shall submit one original and one copy of the application to the Division of Workers' Compensation.

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

(1) Type of Applicant: Insurer or Employer

(2) Name of Applicant

(3) Applicant's Taxpayer Identification Number

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

(5) Division Liaison: Provide the name, title, address, e-mail address, and telephone number of the person designated as the liaison for the Division, who is responsible for receiving compliance and informational communications from the Division and for disseminating the same within the MPN.

(6) The application must be verified by an individual authorized to sign on behalf of the applicant. The verification shall state: "I, the undersigned, have read and signed this report and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this report is true and correct."

(7) Description of Medical Provider Network Plan:

(A) Describe the geographic service area or areas to be served.

(B) The name, license number, taxpayer identification number, and location of each physician as described in Labor Code Section 3209.3, or other providers as described in Labor Code Section 3209.5, who will be providing occupational medicine services under the plan. If the physicians are also part of a medical group practice, the name and taxpayer identification number of the medical group practice shall also be identified in the application.

(C) The name, license number, taxpayer identification number, and location of each entity other than a physician or provider who will be providing medical within the medical provider network;

(D) Describe how the MPN complies with the goal of at least 25% of physicians primarily engaged in the treatment of nonoccupational injuries;

(E) Describe how the covered employees who reside outside of the MPN's geographical service area will be provided with medical treatment;

(F) Describe how the MPN arranges for providing ancillary services to its covered employees;

(G) Describe how the MPN complies with the access standards set forth in section 9767.4;

(H) Describe the employee notification process, and attach a sample of the employee notification material, if available.

(I) Attach a copy of the written continuity of care policy as described in Labor Code section 4616.2.

(J) Attach a copy of the written transfer of care policy that complies with section 9767.8;

(K) Attach any policy or procedure that is used by the applicant to conduct "economic profiling of MPN providers" pursuant to Labor Code section 4616.1 and affirm that a copy of the policy or procedure has been provided to the MPN providers;

(L) Provide an affirmation that the physician compensation is not structured in order to achieve the goal of reducing, delaying, or denying medical treatment or restricting access to medical treatment;

(M) Describe how the applicant will ensure that no person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, when these services are within the scope of the physician's practice, will modify, delay, or deny requests for authorization of medical treatment.

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

(1) Name of Applicant

(2) Applicant's Taxpayer Identification Number

(3) Name of Medical Provider Network, if applicable.

(4) Division Liaison: Provide the name, title, address, e-mail address, and telephone number of the person designated as the liaison for the Division, who is responsible for receiving compliance and informational communications from the Division and for disseminating the same within the MPN.

(5) The application must be verified by an individual authorized to sign on behalf of the applicant. The verification shall state: "I, the undersigned, have read and signed this report and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this report is true and correct."

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

(7) Describe the geographic service area or areas to be served, including the geographic service location for each provider rendering professional services on behalf of the insurer or employer and affirm that this access plan complies with the access standards set forth in section 9767.4;

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

(9) Attach a copy of the written transfer of care policy that complies with section 9767.8 with regard to the transfer of on-going cases from the HCO to the MPN; and

(10) Attach a copy of the policy or procedure that is used by the applicant to conduct "economic profiling of MPN providers" pursuant to Labor Code section 4616.1 and affirm that a copy of the policy or procedure has been provided to the MPN providers.

(f) If the entity is a Health Care Service Plan, Group Disability Insurance Policy, or Taft-Hartley Health and Welfare Fund, in addition to the requirements set forth in subdivision (a)(1-5), a Medical Provider Network application shall include the following information:

(1) The application shall set forth that the entity has a reasonable number of providers with competency in occupational medicine.

(A) The applicant may show that a physician has competency by confirming that the physician either is Board Certified or was residency trained in that specialty.

(B) If (A) is not applicable, describe any other relevant procedure or process that assures that providers of medical treatment are competent to provide treatment for occupational injuries and illnesses.

(g) If a Health Care Organization, Health Care Service Plan, Group Disability Insurance Policy, or Taft-Hartley Health and Welfare Fund has been approved as a MPN, and the entity does not maintain its certification or licensure status, then the entity must file a new Medical Provider Application pursuant to Section 9767.3 (c).

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

Reference: Sections 3209.3, 4616, 4616.1, 4616.2, 4616.3 and 4616.7, Labor Code.

Section 9767.4 Access Standards

(a) This section applies to all applicants except entities that are a Health Care Service Plan, Group Disability Insurance Policy or Taft-Hartley Health and Welfare Fund.

(b) A covered employee must have a residence or work place within 30 minutes or 15 miles of (i) a MPN primary care physician or (ii) a hospital, or if separate from such hospital, a provider of all emergency health care services.

(c) A covered employee must have a residence or work place within 60 minutes or 30 miles of other occupational health services and specialists.

(d) If an applicant believes that, given the facts and circumstances with regard to a portion of its service area, the accessibility standards set forth in subdivisions (b) and/or (c) are unreasonably restrictive, the applicant may propose alternative standards of accessibility for that portion of its service area. The applicant shall do so by including the proposed alternative standards in writing in its plan approval application or in a notice of MPN plan change.

(e) The applicant shall have a written policy for arranging or approving medical care if an employee is working or traveling for work or requires treatment outside of the service area when the need for medical care arises.

(f) The applicant shall have a written policy to allow an injured employee to receive emergency medical treatment from a medical service or hospital provider who is not a member of the MPN.

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

(h) For non-emergency specialist services to treat common injuries experienced by the covered employees based on the type of occupation or industry in which the employee is engaged, the applicant shall ensure that an appointment is available within 20 business days of the applicant's receipt of a referral to a specialist within the MPN.

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

Reference: Sections 4616 and 4616.3, Labor Code.

Section 9767.5 Treatment Standards

(a) The treatment rendered shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines, Second Edition, other nationally developed, peer-reviewed and evidence-based guidelines or, if guidelines have been adopted by the Administrative Director pursuant to Labor Code section 5307.27, the treatment shall be consistent with the adopted treatment guidelines. For injuries not covered by the guidelines adopted by the Administrative Director or, prior to the adoption of those guidelines, ACOEM guidelines, the treatment rendered shall be in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based.

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

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

Section 9767.6 Treatment and Change of Physicians Within MPN

(a) When the injured employee notifies the employer of the injury or files a claim for workers' compensation with the employer, the applicant shall arrange an initial medical evaluation with a MPN physician in compliance with the access standards set forth in section 9767.4.

(b) Within one working day after an employee files a claim form under Labor Code section 5401, the employer or insurer shall authorize the provision of all treatment, consistent with guidelines have been adopted by the Administrative Director pursuant to

Labor Code section 5307.27 or, prior to the adoption of these guidelines, the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, with MPN providers for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for the claim shall be limited to ten thousand dollars ($10,000).

(c) At any point in time after the initial medical evaluation with an MPN physician, the covered employee may select a physician of his or her choice from within the MPN.

(d) The insurer or employer shall notify the employee of his or her right to be treated by a physician of his or her choice after the first visit with the MPN physician and the method by which the list of participating providers may be accessed by the employee.

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

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

Section 9767.7 Medical Provider Network Plan Change

(a) The applicant shall serve the Administrative Director with a Notice of MPN Plan Change before effecting any of the following changes:

(1) A change of 10% or more in the providers participating in the network.

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

(3) Change in policy or procedure that is used by the applicant to conduct "economic profiling of MPN providers" pursuant to Labor Code section 4616.1.

(4) Change in the name of the MPN.

(5) Change of the DWC liaison.

(6) Change in geographic service area.

(7) Change in how the MPN complies with the access standards.

(b) Within 60 days of the Administrative Director's receipt of a Notice of MPN Plan Change, the Administrative Director shall approve or disapprove the plan change based on information provided in the Notice of MPN Plan Change. If the Administrative Director has not acted on a plan within 60 days of submittal of a Notice of MPN Plan Change, it shall be deemed approved.

(c) An applicant denied approval of a MPN plan change may either:

(1) Submit a new request addressing the deficiencies; or

(2) Request reconsideration by the Administrative Director.

(d) Any applicant may request reconsideration of the denial by submitting with the Division, within 20 days of receipt of the Notice of Disapproval, a written request for reconsideration with a detailed statement of the basis upon which reconsideration is requested.

(1) The Administrative Director, or his or her designee, may hold a hearing, at the Division's headquarters offices or such other location as the Administrative Director may designate.

(2) At the hearing, the applicant shall have the burden of establishing qualification for approval.

(3) A hearing for reconsideration of the denial of the plan change shall be informal pursuant to the provisions of the Government Code sections 11445.10 through 11445.60.

(e) The Administrative Director shall issue a written decision within 20 days of the last day of the hearing.

(f) An applicant may seek further review of the decision by filing an appeal with the Workers' Compensation Appeals Board, and serving a copy on the Administrative Director, within twenty days after receipt of the decision.

(g) The applicant shall use the following Notice of MPN Plan Change form:

DWC form #----

Dated:_____

STATE OF CALIFORNIA

Department of Industrial Relations

Division of Workers' Compensation

NOTICE OF MPN PLAN CHANGE

Name of Applicant Entity _____

Applicant's Taxpayer Identification Number _____

Name of MPN (if applicable) _____

Date of initial application approval and MPN approval number _____

Dates of prior plan change approvals _____

Date _____

Address _____

City _____

Zip _____

Phone _____

E-mail _____

Contact person _____

Please give a short summary of the type of the proposed changes in the space provided below and place a check mark against the box that reflects the proposed change.

_____

_____

_____

_____

- ☐ Change in Service Area: Provide documentation in compliance with section 9767.5.
- ☐ Change of MPN name
- ☐ Change of Division Liaison: Provide the name and contact information.
- ☐ Change in Network Providers: Provide the name, license number, and location of each physician by specialty type or name of provider, if other than physician. (Change of 10% or more in Providers)
- ☐ Change in continuity of care policy: Provide a copy of the revised written continuity of care policy.
- ☐ Change in Economic Profiling: Provide a copy of the revised policy or procedure.
- ☐ Other (please describe): Attach documentation.

_____

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

Reference: Sections 4616 and 4616.2, Labor Code.

Section 9767.8 Transfer of Ongoing Care into the MPN

(a) If an injured employee is being treated for an occupational injury or illness by a physician or provider prior to coverage of a medical provider network, and the employee's physician or provider becomes a provider within the MPN that applies to the injured employee, then the applicant shall inform the employee that his/her treatment is being provided by his/her physician or provider under the provisions of the MPN.

(b) The insurer or employer shall provide for the completion of treatment for injured employees who are being treated outside of the MPN for an occupational injury or illness that occurred prior to the coverage of the MPN, including injured employees who pre-designated a physician and do not fall within the Labor Code section 4600(d), for the following conditions:

(1) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a duration of not more than 30 days. Completion of treatment shall be provided for the duration of the acute condition.

(2) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, catastrophic injury, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of treatment shall be provided for a period of time necessary to complete a course of treatment approved by the employer or insurer and to arrange for transfer to another provider within the MPN, as determined by the insurer or employer.

(3) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of treatment shall be provided for the duration of a terminal illness.

(4) Performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

(c) Referrals made to providers subsequent to the inception of the MPN shall be made to a provider within the MPN.

(d) Nothing in this section shall preclude an insurer or employer from agreeing to provide medical care with providers outside of the MPN.

(e) Following determination of the injured employee's medical condition, the insurer or employer shall notify the employee of the determination regarding the completion of treatment. The notification shall be sent to the employee's residence and a copy of the letter shall be sent to the employee's primary treating physician. The notification shall be written in a language common to the workforce in the geographic service area.

(f) If the injured employee disputes the medical determination under this section, the injured employee shall request a report from the employee's primary treating physician that addresses whether the employee falls within any of the conditions set forth in subdivision (a)(1-4).

(g) If the employer or insurer or injured employee objects to the medical determination by the treating physician, the dispute regarding the medical determination made by the treating physician concerning the transfer of care shall be resolved pursuant to Labor Code section 4062.

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

Reference: Sections 4616 and 4616.2, Labor Code.

Section 9767.9 Continuity of Care Policy

(a) At the request of a covered employee, an insurer or employer that offers a medical provider network shall complete the treatment by a terminated provider as set forth in Labor Code section 4616.2(d) and (e).

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

Reference: Section 4616.2, Labor Code.

Section 9767.10 Economic Profiling Policy

(a) An insurer's or employer's filing of its economic profiling policies and procedures shall include:

(1) An overall description of the profiling methodology, data used to create the profile and risk adjustment;

(2) A description of how economic profiling is used in utilization review;

(3) A description of how economic profiling is used in peer review; and

(4) A description of any incentives and penalties used in the program and in provider retention and termination decisions.

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

Reference: Section 4616.1, Labor Code.

Section 9767.11 Employee Notification.

(a) An insurer or employer that offers a Medical Provider Network under this article shall notify each employee in writing about the use of the Medical Provider Network as required by Labor Code section 4616.3 prior to the implementation of an approved MPN, at the time of hire, or when an existing employee transfers into the MPN, whichever is appropriate to ensure that the employee has received the initial notification. The notification shall also be sent to employee at the time of injury. The notification shall be written in a language common to the workforce in the geographic service area. The initial written notification shall include the following information:

(1) the name of the person designated by the applicant to be the MPN contact for covered employees;

(2) a description of MPN services;

(3) how to review, receive or access the MPN provider directory;

(4) how to access initial care and subsequent care;

(5) how to choose a physician within the MPN;

(6) how to change a physician within the MPN;

(7) how to obtain a referral to a specialist;

(8) how to use the 2nd and 3rd opinion process;

(9) how to request and receive an independent medical review; and

(10) a description of the standards for transfer of ongoing care into the MPN; and

(11) a copy of the continuity of care policy as required by Labor Code section 4616.2.

(b) At the time of the selection of the physician for a third opinion, the covered employee shall be notified about the Independent Medical Review process. The notification shall be written in a language common to the workforce in the geographic service area.

Authority: Sections 133 and 4616, Labor Code.

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

Section 9767.12 Denial of Approval of Application and Reconsideration

(a) The Administrative Director shall deny approval of a plan if the applicant does not satisfy the requirements of this article and Labor Code section 4616 et seq. and shall state

the reasons for disapproval in writing in a Notice of Disapproval, and shall transmit the Notice to the applicant by U.S. Mail.

(b) An applicant denied approval may either:

(1) Submit a new application addressing the deficiencies; or

(2) Request reconsideration by the Administrative Director.

(c) Any applicant may request reconsideration of the denial of approval by serving the Division, within 20 days of receipt of the Notice of Disapproval, a written Request for Reconsideration with a detailed statement explaining the basis upon which reconsideration is requested.

(1) The Administrative Director, or his or her designee, may hold a hearing, at the Division's headquarters offices or such other location as the Administrative Director may designate.

(2) At the hearing, the applicant shall have the burden of establishing qualification for approval.

(3) A hearing for reconsideration of the denial of approval of an application or plan shall be informal pursuant to the provisions of the Government Code sections 11445.10 through 11445.60.

(d) The Administrative Director shall issue a written decision within 20 days of the last day of the hearing.

(e) An applicant may seek further review of the decision by filing an appeal with the Workers' Compensation Appeals Board, and serving a copy on the Administrative Director, within twenty days after receipt of the decision.

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

Reference: Sections 4616, Labor Code; 11445.10 through 11445.60, Government Code.

Section 9767.13 Suspension or Revocation of Medical Provider Network Plan; Hearing

(a) The Administrative Director may suspend or revoke approval of a MPN if:

(1) Service under the MPN is not being provided according to the terms of the approved MPN plan.

(2) The MPN fails to meet the requirements of Labor Code section 4616 et seq. and this article.

(3) False or misleading information is knowingly or repeatedly submitted by the MPN or a participating provider or the MPN knowingly or repeatedly fails to report information required by this article.

(4) The MPN knowingly continues to use the services of a provider or medical reviewer whose license, registration, or certification has been suspended or revoked or who is otherwise ineligible to provide treatment to an inured worker under California law.

(b) If one of the circumstances in subsection (a) exists, the Administrative Director shall notify the applicant in writing of the specific deficiencies alleged. The Administrative Director shall allow the applicant an opportunity to correct the deficiency and/or to respond within ten days. If the Administrative Director determines that the deficiencies have not been be cured, he or she shall specify the time period in which the suspension or revocation will take effect.

(c) If the applicant requests reconsideration of the denial of the suspension or revocation, the applicant shall submit with the Division, within 20 days of receipt of the Notice of Action, a written notice of the request for reconsideration with a detailed statement of the basis upon which reconsideration is requested.

(1) The Administrative Director, or his or her designee, may hold a hearing, at the Division's headquarters offices or such other location as the Administrative Director may designate.

(2) At the hearing, the applicant shall have the burden of establishing qualification for approval.

(3) A hearing for reconsideration of the denial of the suspension or revocation shall be informal pursuant to the provisions of the Government Code sections 11445.10 through 11445.60.

(d) The Administrative Director shall issue a written decision within 20 days of the last day of the hearing.

(e) An applicant may seek further review of the decision by filing an appeal with the Workers' Compensation Appeals Board, and serving a copy on the Administrative Director, within twenty days after receipt of the decision.

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

Reference: Section 4616, Labor Code.