Megan Meyer, Esq. March 6, 2025

Certified Specialist, Workers’ Compensation Law

Upon reviewing the recent proposed updates to Title 8 of the California Code of Regulations, specifically section 9767.1 regarding Medical Provider Networks (MPN), I have significant concerns regarding the omission of requirements for MPN interpreters to be certified. I did not become aware of this proposal until this morning, as the comments section had already been closed, but I wish to address this critical issue through this email.

**Lack of Certified Interpreters Compromises Medical Evidence**

The absence of a mandate for interpreters to be certified could critically undermine the integrity of medical reporting within our workers' compensation system. Medical evaluations are pivotal in determining the course of treatment and benefits for injured workers. Without ensuring that these interpreters are certified, we risk the accuracy and reliability of the medical information being conveyed. Perhaps most importantly, when a medical report leads to important legal determinations like permanent disability, temporary disability or even the voracity of the reporting by the injured worker, can any factual statement given to a doctor by way of a non-certified interpreter be deemed substantial medical evidence.  As I attorney I can tell you I would argue that it cannot. A standardized procedure ensuring that all communicated information is accurate is incredibly necessary?

**Potential Consequences of Non-Certified Interpreters**

By not requiring certification for MPN interpreters, we expose the system to several risks, including misdiagnoses, incorrect treatment plans, and unjust legal outcomes (for insurance companies and injured workers alike) due to misinterpreted or inaccurately translated medical assessments.

**Recommendation for Regulation Amendment**

I strongly recommend reconsidering this aspect of the proposed regulations. It is imperative that we establish a rule mandating that all interpreters working within MPN settings are certified. This certification should adhere to stringent standards akin to those required in legal settings, ensuring that all parties can rely on the accuracy and legality of the translated information.  Why would certification not be needed for medical interpretation?  What could possibility be the justification for that?

We must prioritize the quality and reliability of medical reporting to uphold the integrity of our workers' compensation system and protect all stakeholders involved in this process. I urge the regulatory committee to amend this proposal to include a certification requirement for MPN interpreters, thereby safeguarding the rights and health of our state’s workers.

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Renee Ennabe **March 6, 2025**

**Clear and Concise Communications**

I am writing as a certified interpreter and small business owner to express my **deep concern regarding the potential removal of certification requirements** if interpreter services are included as an MPN ancillary service. This decision would have serious consequences for the quality of care provided to injured workers, the integrity of medical interpretation, and the stability of our profession.

Patient Safety at Risk

Medical interpretation is not simply about speaking two languages—it requires rigorous training, cultural competency, and knowledge of medical terminology to ensure accurate, clear communication between providers and patients. Without proper certification standards, unqualified individuals may enter the profession, leading to miscommunication, misdiagnoses, and improper treatments that could put patients’ health and lives at risk.

Legal and Ethical Concerns

Medical providers depend on highly trained, certified interpreters to deliver safe, effective care. If certification requirements are eliminated, healthcare professionals will have no assurance of interpreter competency, creating inefficiencies, legal liabilities, and ethical dilemmas when misinterpretation leads to medical errors or delays in care.

Impact on Small Businesses and Industry Standards

This decision would also devastate small interpreting businesses like mine, which have invested years in training, certification, and maintaining professional standards. It would devalue our expertise, allowing untrained, low-cost labor to flood the industry—prioritizing cost-cutting over quality. We have already seen cases where agencies prioritize unqualified interpreters to save money, compromising the integrity of our work.

A Call to Action

I urge the DIR/DWC to maintain certification requirements for medical interpreters to protect patient safety, uphold professional standards, and prevent unethical cost-cutting practices that threaten the well-being of injured workers. Instead of eliminating these standards, I encourage you to explore solutions that support both qualified interpreters and accessibility for those in need of services.

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**CA Certified Court Interpreter**

As a certified interpreter, I am deeply concerned about the proposal to remove certification requirements if interpreter services are included as an MPN ancillary. Such a decision would have devastating consequences, allowing untrained and unqualified individuals to take over our profession and putting the lives of injured workers at risk. Certification exists to protect those who rely on interpreters in medical settings, and without it, the integrity of our work, the accuracy of communication, and the safety of patients will all be jeopardized.

The role of a medical interpreter is not just about language proficiency; it is about accurately conveying complex medical terminology, cultural nuances, and critical information in high-stakes situations. Without proper training and certification, the risk of miscommunication will skyrocket, leading to dire consequences such as incorrect diagnoses, inappropriate treatments, and, in extreme cases, fatal medical errors. Medical professionals depend on us to facilitate clear and precise communication. If certification requirements are eliminated, these professionals will no longer be able to trust the competence of the interpreters they work with, which will create inefficiencies, delays in care, and potential legal liabilities for healthcare providers and insurers alike.

The removal of certification standards would open the floodgates to individuals who lack the necessary skills, training, and ethical understanding of our profession. This influx of unqualified interpreters would dilute the quality of services, drive down industry standards, and devalue the years of training, education, and experience that certified professionals have worked so hard to attain. The result will not only be lower wages and job instability for qualified interpreters but also an overall decline in the quality of interpreting services available to those who need them most.

Worse still, removing certification requirements would invite unethical practices in the industry, as cost-cutting insurers and agencies would inevitably prioritize cheap, untrained labor over quality services. This shift would encourage fraudulent behavior, such as using bilingual staff members with no interpreting background or hiring individuals who claim to be interpreters without any proof of competency. The consequences of such a move would be disastrous—not only for the profession but for the countless individuals who rely on accurate interpretation to make informed medical decisions.

Being a certified interpreter is more than just a job; it is a responsibility. We are tasked with upholding the highest standards of accuracy, ethics, and professionalism. Stripping away certification requirements threatens the integrity of our profession, the well-being of injured workers, and the trust that medical professionals place in interpreters. It is not just a matter of economic survival for certified interpreters—it is a matter of public safety.

I strongly urge the DIR/DWC to maintain the certification requirement for interpreters in medical settings. Doing so will ensure that injured workers receive the accurate and professional services they deserve while preserving the integrity of our profession. Please do not allow unqualified individuals to jeopardize lives and dismantle the standards that have been established to protect both interpreters and those we serve.

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Pat Cordero **March 6, 2025**

**Spanish Certified Interpreter**

As a Court Certified Interpreter this is very concerning to me.  We have worked so hard to give our profession the value it really deserves and therefore I feel this will be a great disservice to our profession.

There are many people that believe because they call themselves "bilingual" they can do this job.  I have been doing this for over 30 years and I cannot tell you how many times I have heard HORRIBLE MISTAKES from people that believe they have enough knowledge of Spanish when they really don't.  This is a profession that takes a lot of training  and practice so that you can do the job as professional as an attorney does theirs.  Please do not underestimate us.

Please reconsider this.  It will end up hurting a lot of people that rely on our services so that they can get the right message across to the doctors and to their attorneys.

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Katy Park **March 6,2025**

**State Certified Interpreter**

I am writing to join other certified interpreters to voice our opinions on the impending doom that will result if proposed bill passes.

As a certified interpreter, I am deeply concerned that removing certification requirements for interpreter services included as an MPN ancillary will open the door for untrained, unqualified individuals to take over our profession—putting both injured workers and the integrity of our work at risk. Without proper training and certification, miscommunication in medical settings will become rampant, leading to incorrect diagnosis, improper treatment; and ultimately, harm the individuals we are supposed to help. Medical providers rely on us to ensure clear, accurate communication, and without certification standards, they will be left questioning the competency of the interpreters they work with, creating inefficiencies and potential legal liabilities.

This decision would also devastate small interpreting businesses like mine, allowing unqualified individuals to flood the industry and devalue the years of training and expertise we have worked so hard to attain. Worse yet, it would invite unethical practices where cost-cutting insurers and agencies prioritize cheap, untrained labor over quality, further eroding our profession. Being a certified interpreter is more than just a job—it’s a responsibility to uphold the highest standards of accuracy, ethics, and professionalism. Stripping away certification requirements not only threatens my livelihood but also endangers the very people who depend on qualified interpreters to navigate critical medical decisions.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Lisa Anne Hurt-Forsythe**, Vice President, Government Affairs March 5, 2025**

**American Association of Payors Administrators and Networks (AAPAN)**

We would like to thank the Division for its willingness to meet with stakeholders, gather

feedback, and consider multiple points of view when drafting proposed rules. We similarly appreciate the open forum opportunities that the Division has held for the last two years. We were somewhat surprised to see provisions included in this latest draft that were completely new and not vetted or discussed at all in either of the previous drafts or in the open forums. Many of those included provisions would have significant implications for MPN administrators and would create unnecessary and inappropriate new responsibilities in addition to substantial administrative expense to implement. For example, we have serious concerns regarding the conflation of the Medical Provider Networks (governed by the Dept. of Industrial Relations [DIR]) with Preferred Provider Organizations [PPO’s]) (governed by the Dept. of Managed Health Care [DMHC] and the Department of Insurance [DOI]). We likewise have concerns surrounding inconsistent (and sometimes conflicting) definitions and use of terminology in the latest draft.

We have also noted in several different sections throughout the draft that required timelines for MPN Applicants often do not run from *receipt* of notices, documents, *etc*. but rather from state *issuance* of a notice, which diminishes the timeline for an MPN applicant to respond.[[1]](#footnote-1)

Lastly, while we do appreciate the inclusion of new provisions that seek to memorialize processes and procedures that were passed several years ago in statute (such as from SB537 in 2019), we must stress that it has been challenging as MPN administrators to serve the needs of California’s injured workers in the absence of clear written regulations governing these areas. We have instead been operating “informally”, attempting to pivot and respond to rapidly shifting program requirements as they evolved and were released, requiring unexpected and extensive resources from both the business community and the DWC.

We look forward to partnering with the DWC to improve transparency in the system and ensure all stakeholders are operating under a common understanding going forward.

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

We have several comments with respect to the definitions in this section:

(2) **Contracting Agent** – This newly-added definition is not relevant to Medical Provider Networks and instead seems to represent an amalgamation of contract law and cross-references to other sections of California code[[2]](#footnote-2). The MPN regulations are not an appropriate vehicle to address provider contracting, nor is the DWC empowered to override existing contract statutes and regulations. As written, this definition conflicts with the provisions of Labor Code Section 4609 and should be stricken in its entirety.

(15) **Health care shortage** – We are aware this definition was previously existing, but we would like to request some clarification on it. The latter part of the definition as written states that a health care shortage does NOT exist “…where a sufficient number of physicians in that specialty are available within the access standards and willing to treat injured workers under the California workers’ compensation system”. We would like to request that this be expanded to state “…**ready**, willing and **able** to treat injured workers…” This would align this definition with the current rules for Medical Access Assistants (MAA’s) who are obligated to find appointments with providers that are “ready, willing and able” to treat injured workers.

(17) **Medical Practice Group** – We appreciate inclusion of this new definition to clarify how medical practice groups are used in the calculation of access standards. To that end, we would suggest that this definition be re-worded as follows:

“As it pertains to access standards, medical practice group means two or more providers who provide medical care within the same facility, ~~they~~ utilize the

same personnel and divide the income in a manner previously agreed upon by the group”.

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

**Subsection (e)** has been expanded to include “…additional information and documentation as requested by the Administrative Director…” as potential documentation required for a plan application or renewal in addition to documentation submitted with the application itself. We are concerned that this language is overly broad and could encompass documentation that is not appropriate for review by the DWC and which would incur unexpected and extensive resources from both the business community and the state. Instead, this scope should be narrowed as follows:

“…additional information and documentation as requested by the Administrative Director, limited to the information required in the MPN regulations”.

**Subsection (h)** has been added to formalize the process by which an MPN can be voluntarily terminated by an applicant when it is no longer in use. We appreciate the inclusion of this provision.

## **Section 9767.3. Requirements for a Medical Provider Network Plan**

**Subsection (c)** memorializes an informal process currently in use that allows an MPN to submit a subset of information for plan reapproval in situations where there has not been a change to the MPN approved name or MPN number since the last plan approval. We appreciate the inclusion of this section, as it will reduce the administrative burden associated with plan reapproval and avoid duplicative submissions to the DWC

**Subsection (c)(2)** has been expanded to include “Physician License Number” to the required list of data elements for the provider file, as well as a section outlining requirements for the listing of a telehealth-only provider. While we are in support of listing the physician’s license number despite the added administrative cost, we are not in favor of the proposed language addressing telehealth-only -providers. As drafted, telehealth-only providers must list the “…office address filed with the physician’s licensing board”. This office address is not meaningful, is often outdated, is not routinely stored information within a provider record, and is confusing/misleading for injured workers viewing the directory. Although we are aware that statute requires listing of a “physical address” for all providers (even those that are telehealth- only), we have worked with the DWC historically to include a corporate address for a telehealth- only provider, along with a notation in the directory that the provider is “Telehealth Only” so an injured worker is informed that no patients are being seen at the listed address. Although our preference would be to eliminate use of a physical address entirely for telehealth-only providers and include a “Telehealth Only” disclaimer in the directory, at least the corporate address is a data element that we maintain within our databases and can supply to the DWC for submission purposes. Requiring use of the physician’s license address would require MPN administrators to manually look up each telehealth provider’s original licensing information with the licensing board (even if it was submitted 20 years ago) to get the “physician license address”, *even though that address is not meaningful information in any way*. This requirement should be stricken and amended to require use of a corporate (or similar business) address for telehealth-only providers. Furthermore, the “Geographic Service Area” section should be expanded to specify that it is the “Geographic Service Area, as specified by the provider…” This assigns some level of responsibility to the provider to communicate their service area within the state to the MPN.

**Subsection (c)(3)** has also added a new section that ostensibly provides validation information for ancillary providers, and reads as follows:

“…the ancillary service provider file shall have…seven columns in the following order… (7) license number with a board or bureau of the California Department of Consumer Affairs or business registration identification with the Secretary of State or evidence of certification/license with the California Department of Public Health…”

As written, this requirement cannot be implemented consistently and uniformly, as it contains multiple variables and does not distinguish between one ancillary type and another in terms of what information is required to be obtained/validated. The only feasible method by which information of this type could be provided in a consistent/uniform manner would be if the DWC were to publish a list of the appropriate licensing agency or registration board *for each individual ancillary service type* on the DWC’s MPN website, and keep that list updated. Such a list would at least ensure that each MPN applicant is applying the same licensing/validation criteria for each ancillary service type that all other MPN applicants are also providing. Using a list could also provide the DWC with uniform MPN auditing criteria for ancillaries. *In any case, imposing this requirement, even if a validation list by ancillary type is provided, would add a tremendous amount of administrative burden for MPN’s and would likely discourage the MPN’s from including ancillaries within their networks.*

**Subsection (d)(8)(E)** has a newly-added provision that references telehealth-only providers in a similar manner to Subsection (c)(2) above, but with respect to listing these providers in provider directories. As above, we would suggest that the language be expanded to specify that it is the “Geographic Service Area, as specified by the provider…” This assigns some level of responsibility to the provider to communicate their service area within the state to the MPN.

**Subsection (d)(8)(J)** also contains directory requirements for ancillary services, however, several provisions in this section are problematic. First, is the following sentence:

“If the MPN includes ancillary services in its network, [the MPN must] state the web address or URL to the roster of all ancillary services in the MPN…”

This language is confusing in several ways. *There is no “Roster of Ancillary Services” that exists today*. By rule, we currently provide a “Roster of Treating Physicians” and a “Roster of All Participating Providers” (which incorporates all physicians and ancillary providers in the network). The “Roster of Treating Physicians” is a subset of the “Roster of All Participating Providers” but it does offer an injured worker a quicker way to narrow the listing to focus only on treating doctors. We are unclear why this “ancillary roster” is referenced here; was this supposed to be the “Roster of All Participating Providers”, and it was erroneously identified, or is this intended to create a new, third roster? Additionally, we are unclear on what the “web address or URL” being referenced here is referring to. Is this supposed to be the URL for the “Roster of All Participating Providers” that is currently provided on the MPN landing page? Clarification is needed.

This same section also contains the following reference:

“If the ancillary service is providing remote services the geographic service area in California to be serviced by remote service shall be provided and indicate if remote service only is being offered by the ancillary service…”

As above, we would suggest that this language be expanded to specify that it is the “Geographic Service Area, as specified by the provider…” This assigns some level of

responsibility to the provider to communicate their service area within the state to the MPN.

**Subsection (d)(8)(T)** contains the following sentence:

“Describe on the MPN website how to apply to be in the MPN or if not currently accepting new providers a statement that the MPN is not currently accepting new providers. Describe on the MPN website how a participating provider can request to be removed from the MPN.”

We have several comments on this provision. First, MPN’s are frequently comprised of various underlying provider networks, and participation in a given MPN may also require a contractual relationship between a PPO (governed by other areas of California law) and the provider as a condition of participation in the MPN. As such, directions detailing “how to apply” or “how to request to be removed” from an MPN may be multi-faceted and involve several steps and multiple entities. Secondly, providers would need to have a basic understanding of their existing contractual relationship(s)[[3]](#footnote-3) in order to be able to make an informed decision about whether to “opt out” of an MPN. Lastly, the MPN applicant may have additional criteria for MPN provider participation as a supplement to the provider’s network contractual agreement. This criterion would need to be conveyed to the provider with no liability to the MPN applicant in conjunction with “opt in” or “opt out” instructions.

**Subsection (d)(8)(U)** contains some of the most disconcerting provisions. As mentioned in our introductory remarks, the conflation of the Medical Provider Networks (governed by the Dept. of Industrial Relations [DIR]) with Preferred Provider Organizations [PPO’s]) (governed by the Dept. of Managed Health Care [DMHC] and the Department of Insurance [DOI]) is an overreach and is concerning. Subsection (d)(8)(U) epitomizes that concern. The new language states that the MPN must…

“…insure [sic] that the contract between the contracting agent, employer or carrier and the health care provider or health facility provides for an express agreement as to the complete list of the employers, contracting agents and insured that are subject to the agreement and rate under the contract. The contracted reimbursement rates must be established through an express agreement. The medical provider network that provides the Complete Employee Notification to the injured worker must also inform the participating provider of that medical provider network of all notice requirements of Labor Code section 4609...”

As mentioned earlier, the MPN in many (arguably most) situations does not directly contract with providers and is often comprised of one (or several) PPO’s that are solely responsible for the underlying contracts. As such, the MPN is not empowered (legally or pragmatically) to “insure” [sic] contract terms between two outside entities (*i.e.,* the PPO’s and the providers) that are governed by other areas of California law. Furthermore, Section (d)(8)(U) mandates that contracts contain a “…complete list of employers…subject to the agreement…” We question this reference, as PPO’s often contract directly with insurers who in turn write workers’ compensation policies for their insureds (*i.e.,* the employers). In other words, whereas a contractual relationship may exist between an individual employer and an insurer, the PPO is not a party to that contract, much less an MPN. The insurer has the sole discretion to determine which employers it may write policies for, and in turn, which employers are therefore entitled to access the insurers’ PPO contractual terms with providers. The list of potential employers changes continually as employers add/remove/change their workers’ compensation coverage. Imposing a duty(s) on a MPN that is twice removed from an employer/insurer contract is inappropriate as it penalizes MPN’s that are acting in good faith.

The last sentence of Subsection (d)(8)(U) is even more confusing. The “Complete Employee Notice of Medical Provider Network” is the vehicle by which the claims examiner notifies the injured worker of his/her rights within the MPN and is not related to provider contracting disclosures. That same sentence goes on to require an MPN to comply with the “…notice requirements of Labor Code Section 4609…” – the LC §4609 disclosures (not “notices”) are sent to providers at the time of contracting by the PPO’s or other agents that maintain direct contractual relationships with providers. *The MPN’s do not perform this function either*. Neither one of these operational tasks involves MPN’s and this section should be stricken in its entirety. More appropriate avenues to improve transparency in the system should be explored[.[[4]](#footnote-4)](#_bookmark3)

## **Section 9767.5. Access Standards**

We have a few comments on some of the portions of this section as well.

**Subsection (d)** reads:

(d) A workers’ compensation judge or the Workers’ Compensation Appeals Board may determine that an injured worker may seek treatment outside the MPN if the MPN does not have at least 3 primary treating physicians from a different medical practice group.

While we understand that the DWC is trying to ensure that an injured worker may access out-of- network care in a situation where there are inadequate MPN providers, we are concerned that inclusion of this language may inadvertently automatically invalidate MPN’s (that previously met access standards) in more rural areas that may only have one provider group that exists.

Furthermore, we are concerned that inclusion of this provision may incentivize litigation as a “weaponized” effort to by-pass the MPN and obtain out-of-network care. To alleviate these concerns, we suggest adding the following language:

d) A workers’ compensation judge or the Workers’ Compensation Appeals Board may determine that an injured worker may seek treatment outside the MPN if the MPN does not have at least 3 primary treating physicians from a different medical practice group, provided that there are more than 3 primary physicians ready, willing and able to treat workers’ compensation patients from different medical groups available within the geographic service area.

**Subsection (i)** changes the language relating to Medical Access Assistants (MAA’s). We are concerned that this new language may be expanding an MAA’s authority beyond the original intent of the MAA’s, which was simply to schedule appointments and facilitate access to care.

MAA’s are neither qualified nor empowered to “authorize” care, as “authorization” must come from the claims administrator. We are also concerned about the comparatively tight timeframe for “authorization”, as well situations wherein the selected provider is not “ready, willing and able to treat” the injured worker (such as if a preemptory review of records is requested by the selected provider, and/or if the provider decides to decline the patient). As such, we would suggest that this section be reworded as follows:

The MPN medical access assistant shall have the ability to schedule an appointment within the network. ~~The MPN medical access assistant or t~~ Upon request, the employer or insurer or claims administrator shall provide to the

selected provider written authorization scheduling the appointment or send notice to the provider and all parties a written objection to the appointment providing a basis for the objection on a timely basis, unless the selected provider is not ready, willing, and able to treat the injured worker.

We note that **Subsection (i)(2)** repeats the same language with respect to the MAA’s, but instead starts with the following: “…The MPN medical access assistant shall have the **authority** to schedule an appointment…” There is no need to have this language repeated and it should either be removed from this section or removed from the introductory part of Subsection (i). In either case, the language needs to be reworded as indicated above.

## **Section 9767.5.1. Physician Acknowledgments**

Section 9767.5.1 creates a process wherein a physician is asked to “Acknowledge” in writing his participation in an MPN(s). When this process was originally created, the desire was to ensure that the provider was aware of which MPN’s he was participating in. However, this is a static, outdated manual process, and MPN provider participation is fluid and ever-changing. In apparent recognition of this short-coming, **Subsection (d)(3)** was added which would require the MPN’s to re-send Physician Acknowledgements to providers every four years “…unless the MPN can show that the physician has treated workers’ compensation cases for that MPN in the four-year period and the physician has opted into the MPN, for example through a written acknowledgement or an MPN provider data base that complies with section (c).…”

While we appreciate the included reference to an electronic database alternative, since the MPN’s are not necessarily bill review entities, they may not be privy to provider bill activity. *However, the DWC receives copies of every medical billing transaction in the state through state reporting/WCIS and is in a much better position to report on system-wide provider participation.* As such we would like to propose an alternative solution, wherein the MPN would send a “Biannual Notice of MPN Participation” (which could be electronic) to every MPN provider every other year, reminding the provider that they are currently participating in an MPN, and including instructions to the provider on how to “opt out” of the MPN if they would prefer. The notice would instruct the provider that they need not take any action if they would like to continue in the MPN but would remind the provider that they can review their MPN participation at any time and would provide a website reference to allow the provider to verify their MPN participation and/or update their contact information if they wish.

Along with this “Biannual Notice of MPN Participation” sent by the MPN, the DWC could run periodic reports against WCIS, and send the MPN’s a listing of providers that have not treated a Workers’ Compensation patient within the 4-year period (or, alternatively, provide access to an on-line database that houses the same information). The “inactive” provider list should include the provider’s NPI and license number, to ensure that the correct provider is being identified. Then once the MPN is notified of a provider’s “inactive” status, the MPN could take appropriate action to reach out to the provider and/or remove the provider from the MPN directories.[[5]](#footnote-5)

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

This section provides guidelines for obtaining treatment within an MPN and options for an

injured worker to change physicians within an MPN. **Subsection (f)** has been added that creates a new duty for payers to send “…all relevant medical records relating to the claim…” to a “selected physician” within 20 days. This language poses several problems. First, it creates an automatic duty for a claims examiner to send records, which may be duplicative of records that the selected physician has already received. Secondly, there may be medical records that are relevant to the claim that are not in the possession of the claims administrator, and the language as written could potentially penalize a claims administrator for failure to provide copies of records that they do not even have. Thirdly, there is no required “feedback loop” to inform the claims administrator, after a review of the records, that the provider is ready/willing/able to treat the patient. Lastly, the vast majority of MPN treating physicians are well aware of the MPN affiliation of an injured worker, since most referrals are initiated by either the claims examiner and/or the MAA. As such, to avoid unnecessary notices[[6]](#footnote-6), the notification process for MPN-related information should be triggered only upon request by the provider.

To resolve these issues, we suggest the following reworded language:

(f) (1) Upon request by the provider, ~~T~~the insurer or employer shall deliver to the initial primary treating MPN (1) physician selected by the employee, within twenty (20) business days of notice of selected physician, all relevant medical records in the custody of the claims administrator relating to the claim, if any, including the results of diagnostic and laboratory testing done in relation to the injured employee's treatment. Upon receipt of the requested medical records, the provider shall have 48 hours to inform the insurer or employer whether that provider is ready, willing and able to treat the injured worker.

1. The insurer or employer shall advise any subsequently selected MPN physician that any medical record or diagnostic and laboratory test result

deemed relevant by that provider will be delivered upon request. Upon receipt of the requested medical records, the provider shall have 48 hours to inform the insurer or employer whether that provider is ready, willing and able to treat the injured worker.

1. Upon request, ~~T~~the insurer or employer shall also advise ~~all~~ a selected MPN physicians of the relevant MPN identification number, name, telephone number, fax

number, email address, and mailing address of the person or entity to whom a request for authorization and bills should be sent.

We would also like to comment on **Subsection (h)** as it relates to the imposition of penalties. We are unclear why this section is being included within the MPN regulations, as the duties being referenced in this section have no bearing on the administrative functions of an MPN and this section seems to be inappropriately tasking an MPN with overseeing all functions of the delivery of medical care within the Workers’ Compensation system.

For example, we are concerned with the following language:

If a workers’ compensation judge or the Workers’ Compensation Appeals Board determines that authorization for treatment with a MPN provider is unreasonably delayed **as a result of the MPN’s failure to act** an administrative penalty may issue in accordance with regulation section 9767.19(a)(1)(G) [sic] against the MPN.

We are unclear on how a delay for “authorization for treatment” would ever be the

responsibility of an MPN administrator and/or how a delay in the delivery of treatment would be related to an “MPN’s failure to act”. An MPN is not empowered to authorize medical treatment – all authorizations are provided at the behest of the claims administrator. This section is inappropriate and should be stricken as it exceeds the scope of an MPN’s authority and control.

Furthermore, this section appears to be duplicative of later section 9767.19(a)(2) and seems to incorrectly cite §9767.19(a)(1)(G) rather than §9767.19(a)(2)(G).

## **Section 9767.7. Second and Third Opinions**

We noticed some changes in **Subsection (b)** that we would also like to comment on. First, we noticed that a 5-business-day turnaround time has been added for a claims examiner to provide copies of medical reports to a second-opinion physician. We are concerned that this timeframe is too tight and prefer that this be re-worded to read, “on a timely basis”. As mentioned previously, there can be many complicating factors that make delivery of medical reports challenging. For example, sometimes the claims examiner is waiting on a signed release; other times, an electronic file size is too big and the provider is requesting the medical records on paper. For older claims, the medical records may be in off-site storage. The claims examiner should not be penalized in situations where circumstances are beyond their control. This same language and timeframe are repeated in **Subsection (d)** with regards to third opinions, so we would have the same feedback for that subsection as well.

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

We would like to thank the DWC for adding **Subsection (d)** here that clarifies that a Material Modification is not necessary in a circumstance where there has only been a change in the MPN Liaison, and that a 15-day notification to the DWC will suffice. The only request we would make to this subsection is that a notation be added indicating the 15-day notification may be electronic. That said, one issue we would like to point out is that the MPN Plan Modification Form located in **Subsection (k)** has removed a change in MPN Liaison as a “check box”. While that change would seem to be consistent with the **Subsection (d)** wording above, we are concerned that the penalty provision in Section 9767.19(a)(1)(H) with respect to notification of a change in MPN Liaison[[7]](#footnote-7) still remains.

## **Section 9767.12. Employee Notification**

We noticed that **Subsection (a)(2)(B)** has been modified and we appreciate the clarifications added. Since this section is being expanded, we were hoping that the DWC might also consider providing some clarity around what is being sought in the “description of MPN services” (which was previously existing language). Also, we noticed the addition of a reference to the “statewide listing of all participating providers”; we are assuming that this is referring to the “Roster of All Participating Providers” that is currently in use today but would appreciate clarification of the state’s intention if our assumptions are incorrect.

**Subsection (a)(2)(C)** adds what seems on the surface to be an innocuous change, but in fact could have broad reaching implications for several of our members. Specifically, I am referring to the following addition: “The MPN provider directory shall not be password protected…” Today’s MPN application process already requires an MPN applicant to provide detailed access instructions to the state (including passwords) for the provider directories as a standard part of the application process - *i.e.,* the state already has access to all provider directories, even if they are password-protected. Injured workers are provided with password access information for the provider directories (if required) as part of the Complete Employee Notification process, as outlined in Subsection (a).

Given that our members that use password- protected provider directories have made substantial IT infrastructure investments to provide that level of security, removing that function would require costly and time-consuming system changes, modifications to the Complete Employee Notifications, and would trigger Material Modifications for those members.

Since the desire to access a Provider Directory Listing by a party *other* than a state or an injured worker[[8]](#footnote-8) would be comparatively rare, we would like to suggest the following re-wording of this sentence:

If an MPN provider directory requires password protection, then the MPN Applicant shall provide an injured worker covered by the MPN and the Administrative Director explicit instructions for access. If a participating MPN provider would like to access the provider directory, the MPN applicant shall provide access information to the participating provider upon request.

We noted that **Subsection (a)(2)(C)** also has added confirmation of the existing guidelines for the required contents for provider listings. We appreciate this addition to confirm the existing process in writing.

## **Section 9767.14. Probation, Suspension or Revocation of Medical Provider Network Plan; Hearing**

**Subsection(a)(9)** of this section addresses the timelines and processes for an MPN Applicant to request plan re-approval. We have a few comments regarding this proposed section:

1. The resubmission timeline is listed in this section as “…six months prior to the expiration…” This should be changed to “…**180 days prior to the expiration…”** to maintain consistency with Section 9767.2(b).
2. We appreciate that the DWC has recently initiated a process of sending MPN

Applicants a “Reminder Notice” that the 180-day deadline is approaching. This helps to prevent inadvertent MPN suspensions. We would suggest adding this function to the proposed rule language.

1. We had previously provided feedback requesting a reasonable time to “cure” any potential issues identified by the DWC during a plan reapproval as opposed to triggering an “automatic” suspension if the re-approval date passes while the plan is still working with the DWC to secure reapproval. We would like to reiterate that request. The approval process is often iterative, with the DWC requesting clarification and/or additional information, the MPN applicant then responding, and so on. If an MPN Applicant is working in good faith with the DWC during the re- approval process, the MPN should not be “automatically suspended” simply due to the expiration of the 180-day period[[9]](#footnote-9), as unnecessary suspensions cause disruptions for injured workers treating within the MPN, create needless administrative hassles for MPN Plan Administrators, and result in unnecessary work for the DWC.

The language of this section should be re-worded as follows:

“…If the MPN fails to submit a plan for reapproval six months prior to the expiration and the plan is not approved prior to the expiration the MPN ~~shall be~~ ~~automatically~~ may be suspended…”

Use of “may” rather than “shall be automatically” allows the DWC the discretion to decide whether an MPN suspension is warranted, taking all factors into consideration.

**Subsection(a)(11) has been inappropriately added to the MPN rules and should be stricken in its entirety**. Labor Code Section 4609 has no reference whatsoever to Medical Provider Networks and no statutory authority exists to shoulder an MPN with contracting disclosure responsibilities, much less to penalize an MPN for violation of those responsibilities which they may not be involved with or have any control over. As mentioned in our introductory comments, MPN Applicants often defer direct provider contracting to PPO’s, governed by the DOI and DMHC. PPO’s and other contracting entities (as holders with the direct contracts with providers) are the appropriate entities to issue LC §4609 disclosures and are, in fact, issuing these notices today.

## **Section 9767.16. Medical Provider Network Complaints**

**Subsection (a)(2)(A)** and *former* **Subsection (a)(2)(B)** *(stricken in the new draft)* provide rules governing the submission of MPN complaints. We note that the DWC seems to have equated “electronic submission” of complaints with “complaints via e-mail” for the purposes of this section…since Subsection (a)(2)(B) has been stricken, does this imply that an MPN is no longer obligated to respond to complaints that are received by fax, but only by e-mail or postal mail? It would be helpful if this section could be rewritten to clarify. We would also question the rules in a situation wherein a complaint arrives electronically but not via e-mail (such as a website submission, *etc.*)

**Subsection (b)(2)** was also reworded, and the new wording seems more confusing than the original wording. We would like to suggest that this section be reworded to read, “The Administrative Director shall only have the discretion ~~to limit investigations~~ to investigate complaints which provide credible evidence that a violation exists”. Rewording in this manner will solidify the DWC’s intent to restrict the breadth of investigations to only those inquiries that may have merit.

## **Section 9767.18. Random Reviews**

**Subsection (a)(2)(B)** of this section lists documentation that an MPN is obligated to send to the DWC in association with an audit inquiry and many are not new provisions. However, in our re-review of these rules, we began thinking pragmatically about several of the items that are included in this list, questioning why an MPN Applicant would be obliged to send copies of documentation to the DWC that the DWC itself is better equipped to supply. In pertinent part, we are questioning the following:

**(a)(2)(B)(i)** “Documentary proof…that the MPN is still valid and approved…” - The DWC is the entity that approves MPN’s, so we are unclear why the MPN applicant would send this information to the DWC.

**(a)(2)(B)(ii)** “A complete copy of the MPN’s most recent approved plan submission” - By definition, this has previously been “submitted” to the DWC.

**(a)(2)(B)(iv) “…**petitions for suspension or revocation received by the MPN …[or]**…**[d]ocumentation of any administrative actions taken by the Administrative Director against the MPN..” – These documents are *written by the DWC*.

We appreciate the specificity included in the new **Subsection (a)(2)(B)(v)** with respect to Call Logs. We do, however, have two points regarding this new section:

1. the state should specify a retention period for the call logs and
2. this section should only be applicable to call logs on/after the effective date of the regulations.

## **Section 9767.19. Administrative Penalty Schedule; Hearing, Mitigation and Appeal**

**Subsection 9767.19(a)(1)(H)** has been added that creates a penalty for failure of the MPN to inform the DWC when there has been a change in the MPN Liaison within the 15-day timeframe. Our only comment on this section is that it seems inconsistent to add a penalty attached to this provision when this MPN duty has been removed from the list of criteria that are important enough to warrant a Material Modification.

**Subsection 9767.19(a)(1)(I)** imposes penalties on an MPN for “failure to provide Labor Code section 4609 notices”. As noted above in our comments on Section 9767.14(a)(11),

assigning responsibility to an MPN to send LC §4609 notices (which are related to entities that undertake direct provider contracting) is an overreach and is not supported by the statute.

Our comments above bear repeating that MPN Applicants often defer direct provider

contracting to PPO’s, governed by the DOI and DMHC. PPO’s and other contracting entities (as holders with the direct contracts with providers) are the appropriate entities to issue LC §4609 disclosures and are, in fact, issuing these notices today. Penalizing MPN’s for actions (or inactions) of a 3rd party entity is inappropriate. This section should be stricken in its entirety.

**Subsection 9767.19(a)(2)(G)** creates an MPN penalty when “…authorization for treatment was unreasonably delayed due to the [sic] MPN error or mishandling…” Akin to our comments on Subsection 9767.19(a)(1)(I) above, this section appears to create a penalty for failure to complete a task that an MPN is neither equipped nor empowered to handle.

Treatment authorizations are handled by the claims administrator and are not a function of MPN’s. As above, penalizing MPN’s for actions (or inactions) of a 3rd party entity is inappropriate. This section should be stricken in its entirety.

# Article 5.5.0 Rules for Medical Treatment Billing and Payment on or After October 15, 2011

## **9792.5.16: Contract Agreements**

This section in its entirety has no relevance to MPN’s and deals entirely with provider

contracting and banking issues which are governed by completely different areas of law. As we have mentioned repeatedly, provider contracting via PPO’s (and other contracting agents) is already regulated by the DOI and the DMHC and is not part of MPN’s. **Subsection(a)** is a restatement of Labor Code Section 5307.11 explicitly permitting a healthcare provider and an employer to contract for rates that are different than the fee schedule that has erroneously been cited as LC §5307.1. This section is not relevant to MPN’s. **Subsection (b)** merely repeats the flawed definition in 9767.1(2) and is a misstatement of LC §4609(d)(1). **Subsections (c) and** **(d)** address contract terms between healthcare providers and contracting agents, neither of which are relevant to MPN’s. **Subsection (e)** relates to provider reimbursement contracting and banking laws and, again, has no relevance to MPN’s.[[10]](#footnote-10) **Subsection (f)** errantly relies upon Labor Code Section 4603.6 to establish jurisdiction for resolution of *contract disputes* using the Independent Bill Review (IBR) Process. LC §4603.6 clearly states that jurisdiction for IBR is restricted in scope to issues where the “…only dispute is the amount of payment…” and for which the Second Bill Review process has already been followed. In pertinent part, LC §4603.6 states:

(a) If the only dispute is the amount of payment and the provider has received a second review that did not resolve the dispute, the provider may request an independent bill review within 30 calendar days of service of the second review pursuant to Section 4603.2 or 4622

The narrow scope of IBR-eligible disputes has also been recognized in the IBR regulations since the passage of SB863 in Section 9792.5.7(b), which states:

Any other issue, including issues of contested liability or the applicability of a contract for reimbursement rates under Labor Code section 5307.11 shall be resolved before seeking independent bill review.

The DWC is contradicting its own administrative regulations with the proposed addition of 9792.5.16(f).

For all these subsections, the proposed regulations inaccurately cite Sections 133 and 5307.3 of the Labor Code as granting authority. Labor Code Section 133 explicitly gives the DWC authority to “…exercise…any power or jurisdiction conferred upon it under this code…” The Labor Code does not govern Preferred Provider Organizations (or other contracting entities); as mentioned previously, PPOs are overseen by the DMHC and the DOI and numerous statutes and regulations are already in existence in this area. Reliance upon this section to justify the addition of Section 9792.5.16 is unfounded.

In similar fashion, Labor Code Section 5307.3 grants authority to the DWC to draft regulations to “…enforce this Division…” This section does not confer blanket authority upon the DWC to usurp the regulatory authority of other agencies much less oversee contract law generally. Reliance upon this section to justify the addition of Section 9792.5.16 is also unfounded.

In sum, the entirety of Section 9792.5.16 is an overreach and should be stricken in its entirety.

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Steve Peters**, Director March 5, 2025**

**Coventry Government Relations**

**Enlyte**

Thank you for the opportunity to provide feedback and comments on the proposed updates to the MPN regulations found in title 8 California Code of Regulations sections 9767.1 through 9767.19 and the proposed section 9792.5.16. We greatly appreciate the Division of Workers' Compensation’s interest in collecting and understanding stakeholder feedback on these proposed changes to the MPN Regulations.

We are interested in these proposed rule changes because at Enlyte/Coventry we maintain the largest directly contracted property and casualty focused healthcare provider network. Our organization maintains compliance with California state regulations for our contracted partners and has an interest in maintaining a smooth and streamlined process for all workers’ compensation stakeholders to ensure the best overall outcome for injured workers.

As members of the American Association of Payers, Administrators and Networks (AAPAN) our concerns are encapsulated within that organizations feedback regarding these proposed regulations. I would like to especially highlight AAPAN’s concerns with the new definition of Contracting Agent under Section 9767.1, the new requirement for ancillary service license number under Section 9767.3 (c)(3), and the proposed Section 4609 notification requirements under Section 9767.3 (d)(8)(U) and their associated penalties.

We look forward to continuing the dialog with the DWC to make meaningful updates to California’s MPN regulations that provide the best possible care for injured workers in an efficient manner for all system stakeholders.

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Diane Worley**, Executive Director March 5, 2025**

**California Applicants’ Attorneys Association (CAAA)**

The California Applicants’ Attorneys Association offers the following comments regarding the proposed amendments to 8 CCR § 9767.3 (c) (3) and (d) (8) (j) in the Medical Provider Network regulations currently posted on the DWC Forum.

In section 9767.3 (c) (3), the elimination of the language “**if interpreter services are included as an MPN ancillary service, the interpreters listed must be certified pursuant to section 9795.1.6(a)(2)(A) and (B)”** would seriously compromise the language access rights of limited English proficient injured workers. It would also have a chilling effect on professional medical Interpreters who will most assuredly be excluded from participation. It might also disincentivize aspiring Interpreters from pursuing professionalization through training and certification, since none would be required. As written, the regulation would turn back the clock on decades of progress in the rights of limited English proficient individuals to language access.

Additionally, the addition of the reference to certification as provided for in Labor code section 4600(g) in this section is also misguided as LC 4600 (g) references the qualifications for interpreters at medical treatment settings “**that are substantially similar to the requirements set forth in Section 1367.04 of the Health and Safety Code.”**

California's Health & Safety Code §1367.04, originally enacted through SB 853 in 2003, established foundational requirements for language access in healthcare that were the standard at that time. However, these requirements listed under the Health & Safety Code section 1367.04 were established over 20 years ago and **no longer align with modern certification frameworks** developed by the Certification Commission for Healthcare Interpreters (**CCHI**) and National Board for Certification of Medical Interpreters (**NBCMI**), both of which are specified in section 9795.1.6 (enacted in 2013) as eligible credentials for payment for interpreter services.

Due to these outdated standards, CAAA would urge the DWC to preserve the original language in section 9767.3 (c) (3) “**if interpreter services are included as an MPN ancillary service, the interpreters listed must be certified pursuant to section 9795.1.6(a)(2)(A) and (B**)” to support appropriate certification credentials for interpreting services and maintain language access rights.

In section 9767.3 (d) (8) (j), our concern is with this added language “ If the ancillary service is provided by an entity rather than an individual, then that entity’s name, address and telephone number shall be listed” . Allowing an entity to be listed rather than an individual provides a loop hole for carriers to continue replacing certified interpreters with non-certified ones such as with One Call, particularly if this new section supersedes current section 9767.3 (c) (3), which requires that the interpreters providing ancillary services in an MPN be certified. Therefore, it would be important in these regulations to clarify that for interpreting ancillary services, the individual provider’s name be provided so that the appropriate certification can be verified.

Also it is important to recognize the potential for frictional disputes that may be created by listing only entities on MPN listings for medical providers, and not the individual doctors. In *Rivas v. North American Trailer*, [2016 Cal. Wrk. Comp. P.D LEXIS 572](https://advance.lexis.com/api/document/collection/administrative-materials/id/5MBH-0W80-02DC-H241-00000-00?context=1000516), the MPN provider list for the carrier included Casa Colina Transitional Living Center which had multiple specialties. The applicant did designate this facility and selected one physician in particular, although that physician was not specifically described on the MPN list. That physician then submitted an RFA, but the carrier declined the request as being “outside the MPN”. This dispute went to hearing and the WCJ, after hearing the testimony, determined that [Labor Code Section 4616](https://advance.lexis.com/api/document/collection/statutes-legislation/id/4WK3-M0N0-R03P-244T-00000-00?context=1000516)(a)(3) and [Title 8 of California Code of Regulations subsection 9767.5.1](https://advance.lexis.com/api/document/collection/administrative-codes/id/5D4X-N6J0-0012-J00P-00000-00?context=1000516) provide that a designation of a physician within a medical group duly included in an MPN, despite not being listed individually on the MPN list, shall be considered to be providing treatment within the MPN. For this reason, requiring the listing of the individual providers and not just the “entity” should be required in these MPN regulations to avoid these type of unnecessary delays.

Otherwise, there is a lot to like in this MPN rules revision including clarifying when an injured worker can seek treatment outside the MPN when access standards aren’t met (9767.5 (d)) , requiring an update on the physician acknowledgement that they agree to be in the MPN (9767.51 (e) (3), improving contact and listing information on the employee notice of the MPN and removing the password protection (9767.12),requiring more detailed call logs to be provided during random reviews of the MPN (9767.18), and strengthening of administrative penalties (9767.19).

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Catherine Montgomery**, CEO March 5, 2025**

**DaisyBill**

The DWC’s stated purpose of streamlining the review process and enhancing network transparency is commendable. However, I urge the DWC to consider even greater transparency within the MPN system, which too often leaves providers floundering in an unnavigable system.

My comments focus on reducing confusion and clarifying provider participation, such as requiring proof of active provider opt-in for MPN approvals and reapprovals. Likewise, I urge greater specificity related to approved providers and treatment locations, as well as more accuracy in MPN provider counts. Please refer to the table below for a detailed list of all my comments.

I appreciate the DWC’s efforts to improve the MPN system, and thank you for your consideration of my suggestions to enhance provider participation, uphold patient access to care, and minimize administrative challenges.

**Section 9767.3. Requirements for a Medical Provider Network Plan**

(c)(2)...(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), psychiatry (PSY), neurosurgery (NSG), family medicine (GP), neurology (NEURO), internal medicine (IM), physical medicine and rehabilitation (PMR), or podiatry (DPM).

**Comment:** How does DWC prevent double-counting physicians who can act both as a PTP and an additional specialty?

Many primary physicians can be listed as a PTP **and** an additional “provider code” that reports the physician’s specialty.

The PTP designation means the number of physicians in an MPN can be inflated by listing a single physician with multiple provider codes.

For example, an orthopedist can be listed as ORTHO and PTP, which double-counts a single physician in an MPN.

**Section 9767.3. Requirements for a Medical Provider Network Plan**

(c)(2)...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.

**Comment:** Unless an MPN physician signs an acknowledgment, there is no way for the physician to know which MPNs they are in.

It would be helpful if the DWC added that the physician had signed a written acknowledgment agreeing to be in the MPN.

**Section 9767.3. Requirements for a Medical Provider Network Plan**

(c) (4) An MPN determines which locations are approved for physicians to provide treatment under the MPN. **Approved locations** are listed in an MPN’s provider listing; however, an MPN has the discretion to approve treatment at non-listed locations.

**Comment:** The physician's written acknowledgment should include the “**approved locations**.”

Without a written acknowledgment listing approved locations, a physician cannot know that all locations are **not** approved.

There have been instances where the provider received “authorization” to provide treatment; however, reimbursement was denied because treatment was delivered at a non-approved location.

While this type of reimbursement denial violates Labor Code 4610.3, there is no recourse for the provider since authorization is a non-IBR issue.

*“[A]n employer that authorizes medical treatment shall not rescind or modify that authorization after the medical treatment has been provided based on that authorization* ***for any reason,*** *including, but not limited to, the employer’s subsequent determination that the physician who treated the employee was not eligible to treat that injured employee.*

**Section 9767.3. Requirements for a Medical Provider Network Plan**

(d)(8)(E) The roster of treating physicians shall include, at a minimum, the name of each individual provider and provider office address and provider office telephone number. If the treating physician is providing telehealth services the geographic service area in California to be serviced by the telehealth provider shall be provided and indicate if telehealth only is being offered by the physician.

**Comment:** Rather than “provider office address,” the regulations should require the roster to list approved locations for each MPN physician **or** indicate that all locations are approved.

**Section 9767.5. Access Standards.**(a) A MPN must have at least three available physicians of each specialty 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).

**Comment:** An earlier version of the proposed regulatory changes included the following language:

*(a) A MPN must have at least three available physicians* ***which are not affiliated with the same medical practice group*** *of each specialty 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).*

Removing this language allows an MPN to populate the MPN with physicians from a single large practice group.

**Section 9767.5. Access Standards.**

(i)(2) MPN medical access assistants have different duties than claims adjusters…The MPN medical access assistant shall have the ability to schedule an appointment within the network. The MPN medical access assistant or the employer or insurer or claims administrator shall provide to the selected provider written authorization within 5 days of scheduling the appointment or send notice to the provider and all parties a written objection to the appointment providing a basis for the objection. Although their duties are different, if the same person performs both, the MPN medical access assistant’s contacts must be separately and accurately logged.

**Comments:** Is “written authorization” equivalent to a utilization review decision?

Is a specific treatment included in the “written authorization?”

Under what circumstances would a medical assistant “send notice to the provider and all parties a written objection to the appointment providing a basis for the objection.”

What do the “parties” do with that objection?

**Section 9767.5.1. Physician Acknowledgments.**

(d) The acknowledgement shall identify the MPN in which the physician or group participates. Multiple MPNs may be identified in a single acknowledgment or separate acknowledgments or in any combination.

**Comment:** If MPN restricts the locations at which the provider may treat injured workers, the acknowledgment should include all approved locations.

**Section 9767.5.1. Physician Acknowledgments.**

(d) …The MPN or MPNs may be identified by reference to a website listing where a person described in subdivision (b) is enabled to observe which MPN or MPNs are selected for the physician or group.

**Comment:** The physician acknowledgment should include the MPN ID to identify the MPN.

Often, MPNs do not enroll 100% of physicians listed by an entity that provides network services. Accordingly, a provider cannot rely on a website listing to determine if they are enrolled in any given MPN.

The following is quoted from a letter Coventry sends to providers:

“Some of our clients have chosen to customize their MPN. If you are part of First Health Select, Primary or Coventry MPNs, you still may not be part of a specific carrier’s MPN. We [Coventry] advise you to contact the injured employee’s employer to determine who the carrier is and if the carrier considers you part of their specific MPN.”

**Section 9767.5.1. Physician Acknowledgments.**

(e)(3) Beginning June 1, 2026, the acknowledgement shall be obtained every four years unless the MPN can show that the physician has treated workers’ compensation cases for that MPN in the four-year period and the physician has opted into the MPN, for example through a written acknowledgement or an MPN provider data base that complies with section (c).

**Comment:** A four-year period is too long and should be changed to within the last 365 days from the renewal date.

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

(f) The insurer or employer shall also advise all selected MPN physicians of the relevant MPN identification number, name, telephone number, fax number, email address, and mailing address of the person or entity to whom a request for authorization and bills should be sent.

**Comment:** California law requires claims administrators to accept bills electronically. The insurer or employer should provide the clearinghouse and Payer ID used to accept providers’ bills sent.

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

(h) If a workers’ compensation judge or the Workers’ Compensation Appeals Board determines that authorization for treatment with a MPN provider is unreasonably delayed, a penalty of $1,000 shall be assessed.

**Comment:** In order to receive reimbursement, CA requires the provider to obtain a Utilization Review decision authorizing recommended treatment.

It is unclear what “authorization for treatment with a MPN provider” is referencing in this paragraph. The initial medical evaluation? All treatment where the claims administrator failed to respond to an RFA timely?

**Section 9767.7. Second and Third Opinions.**

(c) The second opinion physician may charge for up to two hours of record review under the Official Medical Fee Schedule for this review and determination.

**Comment:** What billing code does the second opinion physician submit for record review? What is the reimbursement for record review?

**Section 9767.7. Second and Third Opinions.**

The third opinion physician may charge for up to two hours of record review under the Official Medical Fee Schedule for this review and determination.

**Comment:** What billing code does the third-opinion physician submit for record review? What is the reimbursement for record review?

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

**Comment:** A modification should be triggered if a MPN removes a specific count or percentage of physicians from the original roster of physicians.

**Section 9767.12. Employee Notification.**

(a)(2)(C) The MPN provider directory shall only list participating providers. The directory shall include, at a minimum, the name of each individual provider and their office address and office telephone number. If the ancillary service is provided by an entity rather than an individual, then that entity’s name, address, and telephone number shall be listed. The MPN provider directory shall list out separately primary treating physicians by name and not by entity in a single searchable list by medical specialty and location.

**Comment:** If an MPN restricts locations where an MPN provider can furnish services, the directory should list approved locations for the provider.

**9792.5.16: Contract Agreements**

a. The contracted reimbursement rates must be established through an express written and executed agreement. All terms regarding pricing and reimbursement rates must be explicitly stated in the contract. The health care provider or health facility licensed pursuant to section 1250 and the contracting agent, employer, or carrier must be parties to the contract for the reimbursement rate to apply. Implied or verbal agreements regarding pricing are not a basis for a reduction in payment.

**Comment:** The contracted reimbursement rates must be established through an express written and executed agreement.

Add “and the contractual agreement is in compliance with Labor Code section 4609, if applicable.”

e. The contract cannot require a health care provider or health facility licensed pursuant to section 1250 to accept virtual credit card payments. Health care providers or health facilities licensed pursuant to section 1250 of the Health and Safety Code have the right to refuse virtual credit card payments and to specify their preferred method of payment within the contract.

**Comment:** Currently claims administrators continue to send providers credit card for payment even after the provider has repeatedly requested payment not be sent via credit card.

The administrative burden credit cards place on providers is enormous: They must call the claims administrator, ask for non-credit card payment, and wait for the delayed payment.

Sometimes, a practice must repeat this process hundreds of times per day.

Many providers accept credit cards that can deduct over 3% of the reimbursement owed since these payments are virtual.

Providers need the DWC's help to stop this payment abuse.

It would be helpful if the provider could file a form indicating the preferred method of payment and claims administrators were penalized penalty and interest when they fail to adhere to the payment request.

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Peter Spalding, Network Specialist March 5, 2025

Liberty Mutual Insurance Company

On behalf of Liberty Mutual Insurance, we very much appreciate the Division’s work to improve California’s Medical Provider Network (MPN) regulations. MPNs are a critical component of the state’s Workers Compensation system, and they play a key role in helping injured workers access quality care. We welcome the opportunity to help spur improvements benefiting California’s injured workers and employers.

In short, we support many parts of the proposal, especially those that streamline processes and address known pain points. However, we have fundamental concerns with some of the proposed contracting requirements; we view those proposals as well-intentioned but counterproductive as currently drafted. We recommend several modifications that would more effectively serve injured workers and employers, and would avoid unintended consequences.

It's important to note that the United States is experiencing a physician shortage that goes far beyond California Workers Compensation. The Association of American Medical Colleges has announced that they expect a shortage of up to 86,000 physicians nationwide by 2036. The healthcare sector has also been disproportionately impacted by the COVID-19 pandemic, which caused many providers to experience financial difficulties, employee turnover, short staffing, and other adverse effects. The impacts to injured workers and employers include fewer available physicians, longer wait times to get appointments, and delays in reporting and billing. These challenges are particularly acute in rural areas and/or unusual specialties, though we also see the effects elsewhere. It will take federal action to fully resolve the shortage, but in the meantime, we support any reforms that will make it easier for injured workers to access quality care.

With that in mind, Liberty Mutual Insurance recommends the following:

# We support the proposal’s streamlined processes, most notably the process for submitting an MPN Application or Plan for Reapproval.

* + An MPN Application or Plan for Reapproval consists entirely of electronic records, but under current law, it can’t be submitted online. CCR 9767.3(c) requires MPN applicants to submit two copies on CDs or flash drives, and to have these items physically delivered to DWC headquarters. A Plan for Reapproval must also include detailed information about the MPN’s policies and procedures, even if DWC had previously approved the same policies and procedures in the past.
  + The proposed revisions to CCR 9767.3(c) would allow MPN applicants to electronically submit a single copy of an MPN Application or Plan for Reapproval. They would also allow a Plan for Reapproval to include a statement under penalty of perjury that its policies and procedures are unchanged from DWC’s prior approval, which would avoid the need to re-submit redundant information to DWC. These changes would simplify the process considerably, and would reduce administrative costs.

# We oppose the proposal’s contracting requirements as currently drafted. Though well- intentioned, the proposed requirements would be ineffective and would create enormous and costly administrative burdens. We would welcome the opportunity to help craft alternatives that accomplish DWC’s goals while avoiding these pitfalls.

* + We agree that providers should be able to easily confirm if they are included in an MPN, and providers should be able to opt out if they wish. However, existing law already contains provisions to that effect. If there are gaps in those laws, we recommend addressing them through the provider acknowledgment process detailed in CCR 9767.5.1.
    - The existing Labor Code 4616(a) requires, among other things, that all treating physicians provide a written acknowledgment before they can be included in an MPN; it also requires MPNs to make available a Roster of All Participating Providers online. CCR 9767.5.1(d) requires physician acknowledgments to list each MPN in which the provider participates, and the acknowledgments must allow providers to opt in or out of each MPN.
    - Under current law, these physician acknowledgments only apply to treating physicians, so they don’t apply to physical therapists, ancillary service providers, or the like. We would support expanding these acknowledgments to cover all participating providers in an MPN. Such a change would ensure that all participating providers have been notified of their MPN inclusion, and that they’ve expressly decided whether to participate or not.
    - That said, the process needs to be as simple as possible. It is often a challenge to recruit providers to accept Workers Compensation cases. In our experience, the most common obstacle is the amount of paperwork required, which providers often view as a poor use of their time; and as noted previously, many providers are short staffed. The proposed CCR 9767.5.1(e)(3) would require providers to sign new acknowledgments every four years unless certain criteria are met. Many providers participate in multiple MPNs, so the added burden of keeping all their acknowledgments up to date could discourage them from participating in MPNs at all.
  + We oppose the language that requires network contracts to include a “complete list of the employers, contracting agents and insured[s]” that are subject to the contract rates. This requirement is impractical and would result in serious unintended consequences.
    - Here too, existing law already contains disclosure provisions. In addition to the acknowledgments noted above, Labor Code 4609 requires contracting agents to disclose network leasing arrangements.
    - Any company’s detailed client list is inherently sensitive and should only be disclosed on a need-to-know basis. Moreover, a major MPN’s client list is constantly changing as new insurance policies take effect, old ones expire, and so on. As currently written, the proposal could require an MPN to amend each and every one of its network contracts—of which there are thousands—anytime a new employer starts using the MPN. It could even prevent new employers from using an MPN at all, since the new employer wouldn’t be listed in the MPN’s existing contracts.
    - Even if it were somehow feasible for MPNs to provide a complete list of enrolled employers, the list would include a lot of information that’s irrelevant to a given provider. That’s because most California employers, including many of the state’s 4.1 million small businesses[[11]](#footnote-11), are enrolled in an MPN; yet only a fraction of small businesses have an injured worker actively treating at a given time, much less have an injured worker in a given provider’s geographical area. In other words, a major MPN’s complete client list is likely to include tens of thousands, or even hundreds of thousands, of employers whose employees are unlikely to ever treat with a given provider. This too would create administrative burdens that could discourage providers from participating in MPNs.
    - There are no such requirements in comparable lines of insurance, nor should there be. For example, group health plans are not required to disclose a complete list of their members to their network providers, much less memorialize this information in their contracts; nor are auto insurers required to disclose a complete list of their policyholders to their contracted auto body shops. Such proposals would be impractical in group health or auto insurance for the same reasons they’re impractical in Workers Compensation.
    - A simple solution to all of this is in the proposed CCR 9767.6(f). We support the provision to have claims administrators[[12]](#footnote-12) advise selected MPN physicians of the relevant MPN on a given case. This would ensure that medical providers have the information they need on a case-by-case basis, while avoiding unnecessary administrative burdens. It would also mirror standard practices in other lines of insurance, such as how group health plans or auto insurers confirm coverage case-by-case.

# We support the proposal to more clearly spell out the duties of the Medical Access Assistants (MAAs). We also recommend some additional improvements.

* + The existing MAA laws are also well-intentioned but difficult to apply in practice. We support reforms to make these laws work more effectively.
* Labor Code 4616(a)(5) requires MAAs to be available at least from 7 a.m. to 8 p.m. Pacific standard time, Monday through Saturday. However, most non-emergency medical providers do not have such extended hours, nor do most claims administrators, law firms, or other stakeholders. Also, since the statute specifies standard time, it requires MAAs to be available as early as 6 a.m. during daylight savings time.
  + - In our experience, most MAA requests come from applicants’ attorneys during regular business hours. On the rare occasion when the MAAs get a request outside of those hours, they’re required to respond by the next calendar day, though there’s very little they can do when providers’ offices are closed. Regardless, we’re required to keep employees on duty to comply with the statutory requirements, which results in unnecessary administrative costs.
    - CCR 9767.3(d)(8)(C) requires MAAs to have a fax number, and CCR 9767.12(b)(1)(C) requires them to have a mailing address. However, since these requirements took effect in 2014, we have no record of ever receiving an MAA request by fax or by mail. All of our MAA requests have come in by either email or phone.
    - CCR 9767.12(a)(2) requires MPNs to notify all injured workers how to contact the MAAs, and to have this information available on the MPN website. However, we often see applicants’ attorneys sending MAA requests to the wrong place. For example, they may send an email to an unrelated email inbox; or they may send a letter to a defense attorney without copying the MAA team.
    - As a practical matter, most non-emergency medical providers request authorization and medical records before agreeing to see a patient. The MAAs are not in a position to handle those types of requests, as they don’t know the case history and must typically defer to the claims adjuster on these issues.
  + We recognize that any statutory changes would require legislative action, which would be outside the scope of the current proposal. That said, we do recommend the following improvements to the regulations:
    - The regulations should more clearly state that that the MAAs have no duty to respond to requests that were never sent to them. Requests must always be sent to the designated toll-free phone number or email address.
    - The regulations should also remove the requirement that MAAs have a mailing address or fax number, as they aren’t used in practice.
    - The regulations should allow the MAAs to respond by the next business day, instead of the next calendar day. This would allow MAAs to more effectively manage requests that come in outside of normal business hours. (In the long run, we would support legislation to remove the requirement that the MAAs be available outside of normal business hours. This would allow us to more closely align our MAAs with our claims adjusters, which would improve coordination between the two.)
    - The regulations should specify that providing authorizations and medical records are duties of the claims adjuster, not the MAA.

# We support provider education, but MPNs are not in a position to give what could be construed as legal advice. Therefore, we oppose the language that requires MPNs to notify providers of the requirements of Labor Code 4609.

* + If DWC wishes to educate providers of these requirements, we would support DWC in doing so. For example, it could post educational information on the DWC website, or it could issue a public memo on the subject. However, Labor Code 4616(a)(1) makes clear that an MPN’s role is to provide medical treatment to injured employees; MPNs were never intended to educate providers as to what the law says. Providers who have questions or concerns about legal requirements should consult an attorney.
  + In addition, Labor Code 4609 expressly applies to contracting agents[[13]](#footnote-13), not MPNs. (Although these two entities work together, they are typically separate entities.) Therefore, even if DWC were to mandate notifications around these laws, they should be the responsibility of the contracting agent, not the MPN.
  + The current proposal is also silent on how these requirements would be implemented. In order for such a proposal to work, it would need to include clear guidelines with a reasonable timeframe for implementation.

# We support the proposed CCR 9792.5.16(f), which specifies that disputes over contract rates shall be resolved through Second Bill Review (SBR) and Independent Bill Review (IBR). We would take it a step further and modify CCR 9792.5.7(b) to remove any exceptions from this rule.

* Existing law already states that disputes over the amount of payment, including disputes over contract rates, are subject to SBR/IBR; and Labor Code 5304 expressly excludes network contracts from the jurisdiction of the Workers Compensation Appeals Board (WCAB). In our experience, the vast majority of contracted providers follow these requirements. However, we’ve seen a small but significant minority of providers who try to proverbially “have their cake and eat it too”: they acknowledge being in-network for the purposes of patient referrals and getting authorization for treatment, but they later refuse to honor their contract rates and try to pursue lien litigation before the WCAB.
  + - These types of liens are typically barred by statute, since liens cannot be filed for disputes subject to SBR/IBR. However, lien representatives often try to get around these rules by claiming that a network contract was somehow defective and therefore unenforceable. CCR 9792.5.7(b) creates a loophole in SBR/IBR, as it provides that “independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested liability *or the applicability of a contract* [emphasis added]… shall be resolved before seeking independent bill review.” This encourages lien representatives to make meritless claims about alleged defects in the contract, in the hopes of bypassing SBR/IBR.
    - We’ve consistently been able to defend against these tactics in litigation, but the costs of litigation still amount to unnecessary frictional costs, and they fail to provide any benefit to injured workers or employers. (This potential for mischief is another reason why we oppose cumbersome contracting requirements.)
  + Fundamentally, the Legislature’s stated intent[[14]](#footnote-14) in creating SBR/IBR was to ensure that billing disputes are resolved by professionals trained in medical billing and in the applicable contracts. The Legislature expressly designed the process to take these disputes out of the hands of Workers Compensation judges who lacked expertise in these areas. Therefore, SBR/IBR should be able to resolve any disputes over the applicability of a contract.

# We oppose the language that imposes new requirements onto MPNs’ online provider directories, including a new Roster of All Ancillary Services. Existing law already requires MPNs to post their complete listings online, including a Roster of All Participating Providers, and to update them regularly. The proposed language would increase administrative costs without adding value for injured workers or employers.

* + In our experience, most injured workers and employers search for providers by referring to an MPN’s online directory. The details of these directories vary by MPN, but they typically allow users to do a targeted search for MPN providers in specific specialties and/or geographic areas. Very few users refer to the statewide rosters, which often include tens of thousands of individual listings.
  + The Roster of All Participating Providers is the only roster required by statute, namely Labor Code 4616(a)(4)(A). When the Legislature enacted the current statute in 2019, it expressly repealed the prior requirement that MPNs make available a Roster of Treating Physicians; and it made clear that its intent[[15]](#footnote-15) was to broaden the types of providers listed.
    - CCR 9767.3(d)(8)(E) was never updated to reflect this legislative change, so it still requires MPNs to maintain a Roster of Treating Physicians. This has forced MPNs to maintain two sets of rosters that are largely redundant. The duplication increases administrative costs yet adds no value for injured workers, medical providers, or other stakeholders.
    - The current proposal does nothing to resolve this issue. On the contrary, the proposed CCR 9767.12(a)(2)(B) would add language requiring MPNs to keep maintaining both existing rosters, plus the proposed CCR 9767.3(d)(8)(J) would require MPNs to add a third Roster of Ancillary Services. This would appear to run counter to the legislative intent to list all MPN providers in a single roster.
  + The proposed CCR 9767.12(a)(2)(C) would also add administrative burdens for both providers and MPNs. Specifically, it would require MPNs’ online directories to “list out separately primary treating physicians by name and not by entity in a single searchable list by medical specialty and location.”
    - Many medical practice groups, including most occupational clinics, prefer to be listed under their group name. By the same token, many employers use these directories to create worksite posters with a list of nearby medical practice groups, to be used in the event of an injury. This arrangement is a win-win for all concerned, because it makes it easier for injured workers to access care, especially immediately post-injury. We acknowledge that there are situations where it does make sense to list physicians individually—and in many areas we do. However, if MPNs were required to do this across the board, then each and every medical practice group would be forced to update its listings each time a physician were to join or leave the group. Providers would also need to confirm which doctors are willing to serve as primary treating physician (as opposed to a secondary treater) and they would need to keep that up-to-date as well. This too would increase providers’ administrative burdens, and it could discourage them from participating in MPNs at all. It would also make finding a provider more cumbersome for injured workers and employers.
    - We recommend continuing to allow providers to be listed either as a medical practice group, or as individual physicians, or a combination of both. This would also mirror standard practices in other areas of healthcare, including group health plans, which allow providers to be listed in an online directory however they prefer to be listed.

We believe that our recommended improvements would help improve access to quality care while reducing administrative costs. This would be a win-win for not just injured workers and employers, but also medical providers and other stakeholders.

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Elena Velez, Certified Healthcare Interpreter March 5, 2025

As a certified interpreter, I am deeply concerned that removing certification requirements if interpreter services are included as an MPN ancillary will open the door for untrained, unqualified individuals to take over our profession—putting both injured workers and the integrity of our work at risk.

Without proper training and certification, miscommunication in medical settings will become rampant, leading to incorrect diagnoses, improper treatment, and ultimately, harm to the very people we are supposed to help. Medical providers rely on us to ensure clear, accurate communication, and without certification standards, they will be left questioning the competency of the interpreters they work with, creating inefficiencies and potential legal liabilities.

This decision would also devastate small interpreting businesses like mine, allowing unqualified individuals to flood the industry and devalue the years of training and expertise we have worked so hard to attain. Worse yet, it would invite unethical practices where cost-cutting insurers and agencies prioritize cheap, untrained labor over quality, further eroding our profession. Being a certified interpreter is more than just a job—it’s a responsibility to uphold the highest standards of accuracy, ethics, and professionalism. Stripping away certification requirements not only threatens my livelihood but also endangers the very people who depend on qualified interpreters to navigate critical medical decisions.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Alma D. Del Real, Claims Regulatory Director March 5, 2025

State Compensation Insurance Fund

Section 9767.1 Medical Provider Networks – Definitions

Subsection (a)(17) provides:

*(17) “Medical Practice Group” means two or more providers who provide medical care within the same facility, they utilize the same personnel and divide the income in a manner previously agreed upon by the group.*

The DWC’s proposed introduction of this term “medical practice group” and its definition may lead to different interpretations of how to comply with access standards. Generally, a medical practice group will have multiple locations. Also, it is vague what the DWC means by “same facility”. Clarity is needed.

**Recommendation:**

For the reasons stated above, State Fund requests clarity in defining this term to ensure MPNs comply with access standards set in the regulations

**Subsection (a)(31) provides:**

*(31) “Remote service” means mode of delivering medical services or goods as allowed in Labor Code section 4600 by a non-physician, including, but not limited to, interpreter services and pharmaceutical services via information and communication technologies to facilitate the diagnosis, consultations, treatment, education, care management and self-management of a patient’s health care while the patient is at the originating site and the ancillary service provider is at the distant site, this mode of health care shall be in compliance with all state and federal laws including privacy laws.*

**Subsection (a)(37) provides:**

(*37) “Telehealth” means a mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultations, treatment, education, care management and self-management of a patient’s health care while the patient is at the originating site and the physician is at the distant site, this mode of health care shall be done by a California licensed physician and in compliance with all state and federal laws including privacy laws.*

State Fund supports the DWC’s intent to add and define these terms under Article 3.5 Medical Provider Networks, as these types of health care services are becoming more widely used for an injured worker’s access to medical treatment in the workers’ compensation system. To avoid ambiguity, we suggest the DWC clarify if the Business and Professions Code (BPC) definitions for the terms *“originating site”* (BPC §2290.5 (a)(4)) and *“distant site”* (BPC §2290.5 (a)(2)) are to be used in this Article.

**Recommendation:**

State Fund requests clarify on the DWC’s use of the terms “originating site” and “distant site” in the definitions for “telehealth” and “remote service.”**9767.3 Requirements for a Medical Provider Network Plan**

**Subsection (d)(8)(H) provides:**

*(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. Telehealth only providers shall not be considered in the access standards calculation for the MPN application as they do not meet the requirements of Business and Professions code section 2290.5. A judge or the Workers’ Compensation Appeals board may consider telehealth only providers in a determination as to access standards.*

The DWC proposes that a workers’ compensation judge (WCJ) or the Workers’ Compensation Appeals Board (WCAB) may exercise their discretion in determining access standards, specifically for telehealth only providers. It is not clear what criteria will be used to make a determination and transparency is needed to understand when and how their authority will apply.

Recommendation:

State Fund requests clarity on how a WCJ or the WCAB will make a determination on access standards with telehealth only providers.

**Subsection (d)(8)(U) provides:**

*(U) Affirm that every contracting agent that sells, leases, assigns, transfers, or conveys its medical provider networks and their contracted reimbursement rates to an insurer, employer, or entity that provides physician network services, or to another contracting agent shall, insure that the contract between the contracting agent, employer or carrier and the health care provider or health facility provides for an express agreement as to the complete list of the employers, contracting agents and insured that are subject to the agreement and rate under the contract. The contracted reimbursement rates must be established through an express agreement. The medical provider network that provides the Complete Employee Notification to the injured worker must also inform the participating provider of that medical provider network of all notice requirements of Labor Code section 4609.*

The proposed changes to this provision are ambiguous and may lead to different interpretations concerning contract requirements and the responsibilities of interested parties. For instance, the proposed changes may be viewed as the need for multiple individual contracts as opposed to a chain of contracts. Additionally, it appears that the DWC intends for the responsibility to notify the participating provider of all notice requirements under Labor Code (LC) §4609 to transfer from the contracting agent to the MPN without guidance on what is deemed “notice” for the purposes of complying with this provision. State Fund is concerned since LC §4609 contains requirements for the contracting agent to disclose information that the MPN does not have access to. This shift in duty to inform is significant and we ask the DWC to consider the impact to the industry.

Recommendation:

For the reasons stated above, State Fund requests:

* Clarity on the contract requirements and responsibilities of interested parties
* Guidance on criteria for what is considered “notice” to comply with the required notification to a participating provider of all notice requirements under LC §4609

Lastly, we recommend the DWC consider how the proposed changes to this provision impact the industry.

9767.5 Access Standards

Subsection (d) provides:

*(d) A workers’ compensation judge or the Workers’ Compensation Appeals Board may determine that an injured worker may seek treatment outside the MPN if the MPN does not have at least 3 primary treating physicians from a different medical practice group.*

The proposed text in this provision creates uncertainty for complying with access standards. One interpretation of the text may be that access standards are not met if any of the three primary treating physicians are from the same medical practice group. Another interpretation of the text may be that there is one physician to treat and at least three physicians from a different medical practice group. State Fund requests clarity.

Additionally, the text of this provision is silent for when and how a WCJ or the WCAB makes their determination to allow an injured to seek treatment outside of the MPN. For purposes of uniformity and guidance on its application, State Fund recommends adding in set standards for making this determination, such as evidence that an injured worker’s treatment has or will reasonably be anticipated to be negatively impacted because the MPN does not have three primary treating physicians from a different medical practice group.

Recommendation:

For the reasons indicated above, State Fund requests clarity on how to comply with this provision.

**Subsection (i) provides:**

*(ii) 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. The MPN medical access assistant shall have the ability to schedule an appointment within the network. The MPN medical access assistant or the employer or insurer or claims administrator shall provide to the selected provider written authorization within 5 days of scheduling the appointment or send notice to the provider and all parties a written objection to the appointment providing a basis for the objection.*

This provision does not specify if the 5-day requirement to provide written authorization for treatment is considered calendar or business days.

Additionally, the 5-day requirement contradicts the timeframe stated under section 9767.5(f) *(currently proposed as (g)),* which provides that the initial appointment for treatment be “*available within 3 business days of a covered employee’s notice to an MPN medical access assistance that treatment is needed.”*

Clarity is needed to determine if calendar or business days were meant for the 5-day requirement and consistency in application is needed with related regulations to ensure timeframes are met for coordinating and providing medical treatment.

**Recommendation:**

To avoid conflict and misinterpretation, State Fund requests:

* Clarity in this provision to specify use of calendar or business days for the 5-day requirement
* Consistency with other regulations to avoid conflict and misinterpretation with required timeframes for the provision of medical treatment

**9767.6 Treatment and Change of Physicians within MPN**

**Subsection (h) states:**

*(h) If a workers’ compensation judge or the Workers’ Compensation Appeals Board determines that authorization for treatment with a MPN provider is unreasonably delayed, a penalty of*

*$1,000 shall be assessed. This penalty shall be treated as a separate species of penalty under Labor Code 5814(e) and may be appropriately assessed at trial, including Expedited Hearings pursuant to Labor Code 5502(b)(1). If a workers’ compensation judge or the Workers’ Compensation Appeals Board determines that authorization for treatment with a MPN provider is unreasonably delayed as a result of the MPN’s failure to act an administrative penalty may issue in accordance with regulation section 9767.19(a)(1)(G) against the MPN. The workers’ compensation judge or Workers’ Compensation Appeals Board shall determine the cause of the delay and make and serve a specific finding on the Division of Workers Compensation at the time of decision finding an unreasonable delay.*

As proposed, it is unclear what the DWC intended with creating this provision. One interpretation may be to create a new penalty payable to the injured worker, one that is separate from existing penalties for unreasonable delay as defined in LC §5814. Another interpretation could be that the DWC intended to limit a LC §5814 penalty imposed to $1,000.00. Clarity is needed.

Also, the reference to §9767.19(a)(1)(G) is not the correct regulation section to cite in relation to this penalty provision for the unreasonable delay of authorization for treatment with an MPN provider. Instead, it appears the DWC meant to reference §9767.19 (a)(2)(G), the newly proposed subsection for the imposition of an administrative penalty pursuant to a WCJ or WCAB’s finding that authorization for treatment was unreasonably delayed.

**Recommendation:**

To avoid ambiguity and ensure compliance, State Fund suggests the DWC provide clarity on how the penalty described in this provision is assessed and applied, including reference to related regulations.

**Section 9767.12 Employee Notification**

**Subsection (2)(B) provides:**

(*B) A description of MPN services as well as the MPN’s web address for ~~more~~ information about the MPN including how to contact the MPN contact and medical access assistants and information about how to obtain a copy of MPN employee notification as required by regulation 9767.12 and the web address that includes a roster of all treating physicians and the complete statewide listing of all participating providers in the MPN;*

The proposed changes to this provision are vague as to whether the statewide listing of all participating providers needs to be included with the MPN employee notification as a separate attached list or be accessible via the web address. Clarity is needed as there is significant impact to administrative costs associated with the provision of the statewide listing of all participating providers with the MPN employee notification vs. ensuring the listing is accessible via the web address.

**Recommendation:**

For the reasons stated above, State Fund requests clarity to ensure compliance in the manner intended under this provision.

State Fund supports the DWC’s intent to streamline processes, show transparency of the networks, and provide clarity with access standards.

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Isis Bolanos, Operations Manager March 5, 2025

Santana, Lopez & Associates, LLC

We are a Language Service Company servicing Workers’ Compensation Injured workers since 1993. After reviewing the proposed changes to the certification requirements, specifically page 9, I am left wondering if the DWC no longer cares about the rights of injured workers? You have proposed removing the section that requires interpreters within an ancillary service MPN to be certified and replacing it with LC 4600 (g) that refers to the very outdated Section 1367.04 of the Health and Safety Code that does not require interpreter certification.

The intent of SB 863 in 2012 was to protect the rights of injured by requiring interpreters listed in an ancillary MPN be certified, but now it seems the DWC is moving backwards. Interpreters have repeatedly asked for the loophole allowing the carrier to use “provisionally certified” individuals be closed, but instead, you have given them a green light to systematically replace certified Interpreters with non-certified individuals within their MPN.

I urge the DWC to reconsider this proposal and secure high-quality, competent language services to injured workers by keeping the certification requirements within the ancillary service MPN in place.

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Noemi Meza-Diaz March 5, 2025

As the bilingual Office Manager of a workers' compensation law firm, I am writing to express my concern regarding the proposed regulations that would remove interpreter certification requirements if interpreter services are included as an MPN ancillary. I have witnessed firsthand the challenges that arise when a certified interpreter is not present at medical appointments. Without certified interpreters, who possess specialized training in medical terminology and ethics, patient care is compromised. Medical providers would face difficulties verifying interpreter competency, leading to inefficiencies, miscommunication, and potential legal liability due to medical errors.

Moreover, small interpreting businesses would suffer as professional standards are undermined and unqualified providers enter the industry. The lack of certification requirements could also encourage unethical practices, allowing insurers and language service providers to prioritize cost savings over quality. This may lead to increased reliance on untrained bilingual staff or family members, further jeopardizing accurate communication in medical settings.

California has long recognized the importance of professional medical interpreters in ensuring accurate communication. I believe this change would have detrimental effects on injured workers, medical providers, and the interpreting industry. I strongly urge the DIR/DWC to keep the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Sara Widener-Brightwell March 5, 2025

SVP Claims and General Counsel

California Workers’ Compensation Institute

The Institute offers the following comments:

**Section 9767.1(a)(2):**

The proposed definition for “Contracting Agent” references *a preferred provider organization as defined in title 5 California Code of regulations section 4610*. Title 5 California Code of Regulations section 4610 concerns the UPC.

The Institute recommends removal of this incorrect reference.

**Section 9767.1(a)(31):**

The proposed definition for “Remote Service” references services delivered by non-physician providers, but includes activities performed by physician providers including diagnosis and consultations.

The Institute recommends eliminating reference to services generally performed by physicians.

**Section 9767.2(h):**

The Institute recommends the following language for clarity.

*An MPN applicant may choose to terminate an approved MPN that was implemented and is no longer in use by transmitting a letter signed by the MPN applicant’s authorized individual to the Administrative Director. The termination letter shall include the name and identification number of the MPN, the termination effective date, and affirmation that all covered employees will be notified of the termination and of the continuity of care plan prior to the termination of the MPN.*

**Section 9767.3(d)(8)(E):**

This section requires that *If the treating physician is providing telehealth services the geographic service area in California to be serviced by the telehealth provider shall be provided* and indicate if telehealth only is being offered by the physician.

To avoid additional administrative burden, the Institute recommends that the geographic service area for a telehealth provider be required only if the provider is limiting provision of telehealth services to a subset of California.

**Section 9767.3(d)(8)(H):**

This section is inconsistent. It states that *Telehealth only providers shall not be considered in the access standards calculation for the MPN application as they do not meet the requirements of Business and Professions code section 2290.5. A judge or the Workers’ Compensation Appeals Board may consider telehealth only providers in a determination as to access standards.*

The Institute recommends that telehealth only providers be considered in the access standards calculation for the MPN application, since their presence may be considered by a WCJ or the WCAB. This is a particular concern in rural areas that are currently underserved by medical providers. We also request clarification of the contention that telehealth only providers do not meet the requirements of Business and Professions code section 2290.5

**Section 9767.3(d)(8)(J):**

As recommended in section 9767.3(d)(8)(E), to avoid additional administrative burden, we suggest that the geographic service area for an ancillary telehealth provider be required only if the provider limits the provision of telehealth services to a subset of California.

**Section 9767.3(d)(8)(U):**

The Institute request clarification of whether the requirement that the *contract between the contracting agent, employer or carrier and the health care provider or health facility provides for an express agreement as to the complete list of the employers, contracting agents and insured that are subject to the agreement and rate under the contract* applies to all employers whether insured or self-insured, and to all carriers. The relationships between employers, carriers and contracting agents are fluid. Requiring contractual changes whenever these relationships change would be untenable.

This language appears to be misplaced in a section that addresses the requirements of the MPN plan. *The medical provider network that provides the Complete Employee Notification to the injured worker must also inform the participating provider of that medical provider network of all notice requirements of Labor Code section 4609*.

**Section 9767.5(d):**

This section requires *at least 3 primary treating physicians from a different medical practice group.*

Labor Code section 4616(a)(2) states that *the administrative director shall consider the needs of rural areas, specifically those in which health facilities are located at least 30 miles apart and areas in which there is a health care shortage.* Requiring at least 3 primary treating physicians from a different medical practice group may adversely impact access in rural areas. The Institute recommends removing that language.

**Section 9767.5(h), Section 9767.5(h)(2):**

The new language in these sections is repetitive. The Institute recommends deleting the proposed new language from section 9767.5(h)(2).

**Section 9767.6(h):**

The Institute requests further clarification of what is considered an unreasonable delay in authorizing treatment, and the basis for a set penalty of $1000 for any unreasonable delay, given Labor Code section 5814(a). It is also unclear what would constitute a failure to act by the MPN that would result in an authorization delay. It appears the references to Labor Code section 5814(e) and section 9767.19(a)(1)(G) are misplaced.

**Section 9767.8(d):**

The Institute supports the elimination of a change in MPN liaison from the list of events requiring a plan modification.

**Section 9767.12(a)(2)(B):**

The addition of the requirement to include *information about how to obtain a copy of MPN employee notification* in this section which addresses the content of the MPN employee notification seems to be misplaced.

**Section 9767.14(a)(9):**

This section addresses the MPN status of new claims filed during the period an MPN is suspended. As the claim was never within the MPN, the Institute recommends the removal of “back” from the last sentence.

**Section 9767.19(a)(1)(I):**

Section 9767.19(a)(1) addresses MPN filing requirements with the DWC. Proposed sub-section (I) appears to be misplaced as it involves providing notices to providers.

**Section 9767.19(a)(2)(G):**

Clarification of what constitutes MPN error or mishandling is necessary. Would this penalty be assessed against the MPN or the MPN applicant?

**Section 9767.19(i):**

Clarification of the period in which a penalty must be paid or appealed is necessary.

**Section 9792.5.16:**

As noted in section 9767.1(a)(2), the reference to title 5 California Code of regulations section 4610 is incorrect.

**General recommendation:**

The proposed regulations frequently add *or claims administrator* to the current text referencing the employer or insurer. For simplicity, the Institute recommends using claims administrator only.

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Yaritza Alvarez March 5, 2025

I am writing to express my concern about the potential removal of certification requirements for interpreter services if they are included as an MPN ancillary.  
  
I am bilingual, speaking two languages (English and Spanish) and I previously worked at a medical facility. As such, I understand the importance of clear communication with patients. However, my language skills alone did not qualify me to interpret medical conversations. In the past, I have been asked to interpret in the absence of a certified interpreter, and I worry that this practice may increase if certification is no longer required.  
  
Medical terminology is complex, and misinterpretations can have serious consequences for patients and staff. Patients deserve the expertise of trained and certified interpreters who can accurately convey medical information.  
  
Removing the certification requirement would jeopardize patient safety, increase the workload for staff like myself, and potentially create liability issues. I strongly urge you to maintain the current standards and ensure that only certified interpreters are utilized for medical interpretation.

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Basil Besh, M.D., Chair March 5, 2025

California Orthopaedic Association

Section 9767.1 (a)(2)

TPAs and MPNs are agents working on behalf of self-insured employers/Workers’ Compensation payors. We support adding them to this definition and holding them responsible for their contracting activities, in addition to, but not in lieu of, the self-insured employer/Workers’ Compensation payor for whom they are working.

9767.1(a)(17)

Commenter recommends the following revised language:

(17) “Medical Practice Group” means two or more providers who provide medical care and bill under the same tax ID number.

We believe that what the Division is trying to address in this definition is that to be considered as a medical practice group, they would have to bill under the same tax ID number. We believe this is a more reliable approach rather than conditioning the definition on using the same personnel and how they divide income. We suggest this revised language to make this more straightforward.

9767.1(a)(30)(C)

Providers really fall into three broad categories. The first is Occupational Medicine providers who are dedicated to treating injured workers. There does not seem to be a shortage of Occupational Medicine providers in California dominated by Concentra. The second are provider specialties that commonly handle Workers’ Compensation injuries. This broadly includes orthopaedic surgeons, neurologists, physiatry, pain management, neurosurgery (for spine), etc. The third are providers who rarely treat work comp injuries. Examples include urology, nephrology, ob/gyn, etc.

We would recommend individual rules for each of the categories. It simply makes no sense to mandate 3 orthopaedic surgeons and 3 urologists in a given area within the state. Rare specialties should be utilized on an “any willing provider” basis at OMFS rates and exempted from many of the administrative hassles of current work comp to encourage them to treat injured workers. It is difficult for practices to do a little Workers’ Compensation as the Workers’ Compensation system requires a specialized infrastructure to support the process, e.g., utilization review, IBR, and IMR, etc. The financial exposure is limited for payors based on the lack of frequency of need for these specialized services and the potential for gamesmanship is equally limited. Most of what is proposed here ONLY applies to the second category. For example, things like accepting a discount so that the payor can market you to employers clearly does not apply to nephrologists.

We urge the Division to develop individual rules for each category of medical providers applicable to their need to be available to treat injured workers.

9767.1(a)(31)

COA supports the use of remote services for injured workers. We question why this definition is limited to just non-physicians. We recommend expanding remote services to include all physician and non-physician services.

If you intend to have remote services apply to only non-clinical services, you would have to exclude physical therapists from the remote definition since they are not included in the physician definition. So, assuming they would be included under the “non-physician” services. We don’t believe this is what you are intending. Physical therapy services are much different than services rendered by an interpreter.

Also, we are unclear what is meant by “pharmaceutical services.” Are you envisioning that a pharmacist would be rendering some type of remote service? Please clarify.

9767.1(a)(37)

We support the inclusion of this definition to make clear that telehealth services are available to injured workers.

9767.1(a)(40)

Commenter recommend the following revised language:

(40) “Treating physician” means any physician within **or outside** 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.

We recommend adding “or outside” to include all treatment rendered to injured workers.

**9767.3 (c)**

Commenter recommends the following revised language in bold:

(c) All MPN applicants shall complete the section 9767.4 Cover Page for Medical Provider Network Application or Plan for Reapproval with an original signature or electronic signature, and an MPN Plan meeting the requirements of this section or the optional MPN Plan Application form. One copy of the completed, signed Cover Page for Medical Provider Network Application or Plan for Reapproval and the complete MPN Plan shall be submitted to the DWC in compact discs or flash drives or to an electronic address in word-searchable PDF format. The hard copy of the completed, signed original Cover Page for Medical Provider Network Application or Plan for Reapproval and the complete MPN Plan shall be maintained by the MPN applicant and made available for review by the Administrative Director upon request. Electronic signatures are accepted. If the MPN provides a written statement under penalty of perjury that the MPN Plan name and MPN Identification number submitted and approved by the DWC on a specific date has not changed the DWC will accept the cover page, **and** an updated roster of all treating physicians **actively participating in their MPN. The** prior approved plan does not need to be resubmitted. **If the MPN has leased a network of providers and the Division has relied on this information to determine that the MPN is meeting the required access standards, the MPN must allow all providers in the PPO network to actively participate in the MPN.** This submission including the previously approved plan will be subject to a review in accordance with statues and regulations.

We understand that MPNs in their application, represent to the Division that they are using, for example, the Anthem PPO network to form their list of providers in the MPN. The Division approves the MPN based on this broad network. But, then the MPN goes through the Anthem PPO network list and in reality, only allows a select group of providers in the PPO network to actually participate in the MPN.

We believe this inaccurately represents to the Division the number of providers actually available to injured workers in the MPN and has a significant impact on injured workers’ access to needed medical care.

If the MPN represents to the Division that their MPN is utilizing/leasing certain PPO networks to satisfy the access requirements, we believe the Division should require the MPN to allow all providers in the PPO network to actively participate in the MPN.

**9767.3 (d)(8)(A) and (d)(8)(E)**

Commenter recommends the following revised language in bold:

(A) **Provide evidence** that the MPN network is adequate to handle the expected number of claims covered under the MPN and explain how this was determined;

(E) State the web address or URL to the roster of all treating physicians in the MPN. Affirm that secondary treating physicians who are counted when determining access standards but can only be seen with an approved referral are clearly designated “by referral only”. The roster of treating physicians shall include, at a minimum, the name of each individual provider and provider office address and provider office telephone number. If the treating physician is providing telehealth services the geographic service area in California to be serviced by the telehealth provider shall be provided and indicate if telehealth only is being offered by the physician. **If the MPN is leasing PPO networks to form the list of providers included in the MPN, the MPN must allow all providers within the PPO network to actively participate in the MPN.**

We actually believe that allowing MPNs to lease PPO networks to form their MPNs has caused problems and confusion – problems for injured workers accessing medical care, problems for medical providers as excessive discounts are applied to their medical treatment bills causing them to drop out of the Workers’ Compensation system, and problems for the Division in verifying MPN networks.

We believe it’s time to sunset the leasing of PPO networks. One medical provider could be listed in hundreds of MPNs because the MPNs all leased the same PPO network. It would be humanly impossible for that one medical provider to treat injured workers, in a timely manner, under all those MPNs. Thus, allowing multiple MPNs to lease the same PPO network makes it nearly impossible for the Division to verify which medical providers are actually treating under each MPN and decide whether the MPN is meeting their access standards.

Perhaps allowing the use of leased PPO networks was important when MPNs were first formed, but payors and self-insured employers have now had 10-12 years to form their own networks of preferred medical providers. Leasing someone else’s PPO network should no longer be necessary or allowed.

In fact, some self-insured employers already had their list of preferred medical providers long before MPNs were even created. Other MPNs who did initially lease a PPO network to form their MPN have had time to go through the PPO list and select medical providers that they want in their preferred medical provider network.

It has been our experience that not all medical providers in a PPO network are allowed to actively participate in the MPN. MPNs use the entire PPO list to meet the Division’s MPN access standards, but then they go through the list and only allow a portion of the medical providers to actively participate in the MPN. This is also misleading to the Division since not all medical providers in the PPO network are allowed to actually participate in the MPN.

We believe it is time for the MPNs to stand on their own and no longer be allowed to lease PPO networks to form a MPN. We believe this was the legislative intent of the MPN legislation. We understand that this could be disruptive to some MPNs who have relied solely on the leasing of PPO networks, so we would recommend a phase-in of the prohibition on allowing MPNs to lease PPO networks of no more than 3 years.

We believe this one change could make a tremendous difference in the Division’s efforts to validate medical providers actively participating in their MPN.

**9767.3 (d)(8)(T)**

Commenter recommends the following revised language in bold:

(T) Describe the MPN’s procedures, criteria and how data is used to continuously review quality of care and performance of medical personnel, utilization of services and facilities, and costs. Describe on the MPN website how to apply to be in the MPN or if not currently accepting new providers a statement that the MPN is not currently accepting new providers. Describe on the MPN website how a participating provider can request to be removed from the MPN. **Should a provider request to be removed from the MPN, the provider will be removed and the MPN provider directory updated within 30 calendar days.**

In the MPN’s procedural description to the Division, we believe it is important that the MPN state that it is their policy to remove a provider from their MPN provider directory within 30 calendar days of being notified that the provider is requesting they be removed. It is vital to ensure timely and appropriate care to injured workers that MPN rosters be as accurate as possible.

**Section 9767.4 Cover Page for Medical Provider Application or Plan for Reapproval**

Number 6

Add check box: **Name of any leased, purchased, transferred or conveyed PPO network(s) utilized by the MPN**

Number 9

Revise to state: MPN Medical Provider On-line Portal

Section 9767.5 Access Standards

Commenter recommends adding the language “which must include the MPN name and ID number.

(i) 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. The MPN medical access assistant shall have the ability to schedule an appointment within the network. The MPN medical access assistant or the employer or insurer or claims administrator shall provide to the selected provider written authorization within 5 days of scheduling the appointment **which must include the MPN name and ID number** or send notice to the provider and all parties a written objection to the appointment providing a basis for the objection.

(i)(2) MPN medical access assistants have different duties than claims adjusters. 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. The MPN medical access assistant shall have the authority to schedule an appointment for the injured worker within the network. The MPN medical access assistant or the employer or insurer or claims administrator shall provide to the selected provider written authorization within 5 days of scheduling the appointment **which must include the MPN name and ID number** or send notice to the provider and all parties written objection to the appointment providing a basis for the objection. Although their duties are different, if the same person performs both, the MPN medical access assistant’s contacts must be separately and accurately logged.

**Section 9767.5.1. Physician Acknowledgments.**

**(b)(2) Change 90 days to 30 calendar days**

Commenter recommends the following revised language in bold:

(d) The acknowledgement shall identify the MPN in which the physician or group participates, **include a description of who is covered by the MPN, and list any leased, bought, transferred, or conveyed networks utilized by each MPN**. Multiple MPNs may be identified in a single acknowledgment or separate acknowledgments or in any combination. Any form that presents more than one MPN for the physician’s acknowledgment shall enable the physician either to opt in or to opt out of each MPN. The MPN or MPNs may be identified by reference to a website listing where a person described in subdivision (b) is enabled to observe which MPN or MPNs are selected for the physician or group. If permitted by the written acknowledgment, the website listing may be amended without further action by the physician or the group, provided that the website enables the physician or the group to de-select any MPN. If the physician or group is removed from an MPN by anyone other than a person described in subdivision (b), the MPN applicant shall give the physician or group notice of that fact in writing or electronically **within 30 calendar days of the removal.**

**Add the following new language:**

**(e)(3) The Medical Provider Network adds a leased, bought, transferred, or conveyed network to their Medical Provider Network.**

**Renumber (3) to (4) and revise as follows:**

(4) Beginning June 1, 2026, the acknowledgement shall be obtained every **two** years unless the MPN can show that the physician has treated **at least 25** workers’ compensation cases for that MPN in the **immediate two** year period and the physician has opted into the MPN **at some point**, for example through **an initial** written acknowledgement or an MPN provider data base that complies with section (c).

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

**Recommended changes in bold.**

(f) The insurer or employer shall deliver to the initial primary treating MPN physician selected by the employee, within twenty (20) **calendar** days of notice of selected physician, all relevant medical records relating to the claim, if any, including the results of diagnostic and laboratory testing done in relation to the injured employee's treatment. The insurer or employer shall advise any subsequently selected MPN physician that any medical record or diagnostic and laboratory test result deemed relevant by that provider will be delivered upon request. The insurer or employer shall also advise all selected MPN physicians of the relevant MPN identification number, name, telephone number, fax number, email address, **name of clearinghouse for an EDI transmission, and** mailing address of the person or entity to whom a request for authorization and bills should be sent.

(h) If a workers’ compensation judge or the Workers’ Compensation Appeals Board determines that authorization for treatment with a MPN provider is unreasonably delayed, a penalty of $1,000 **per instance** shall be assessed. This penalty shall be treated as a separate species of penalty under Labor Code 5814(e) and may be appropriately assessed at trial, including Expedited Hearings pursuant to Labor Code 5502(b)(1). If a workers’ compensation judge or the Workers’ Compensation Appeals Board determines that authorization for treatment with a MPN provider is unreasonably delayed as a result of the MPN’s failure to act an administrative penalty may issue in accordance with regulation section 9767.19(a)(1)(G) against the MPN. The workers’ compensation judge or Workers’ Compensation Appeals Board shall determine the cause of the delay and make and serve a specific finding on the Division of Workers Compensation at the time of decision finding an unreasonable delay.

**Section 9767.7. Second and Third Opinions.**

**Recommended changes in bold.**

(b) If the covered employee disputes either the diagnosis or the treatment prescribed by the primary treating physician or the treating physician, it is the employee's responsibility to: (1) inform the person designated by the employer or insurer or claims administrator that he or she disputes the treating physician's opinion and requests a second opinion (the employee may notify the person designated by the employer or insurer or claims administrator either in writing or orally); (2) select a physician or specialist from a list of available MPN providers; (3) make an appointment with the second opinion physician within 60 days; and (4) inform the person designated by the employer or insurer or claims administrator of the appointment date. It is the employer's or insurer's or claims administrator’s responsibility to (1) provide at least a regional area listing of MPN providers and/or specialists to the employee for his/her selection based on the specialty or recognized expertise in treating the particular injury or condition in question and inform the employee of his or her right to request a copy of the medical records that will be sent to the second opinion physician; (2) contact the treating physician, provide a copy of the medical records or send the necessary medical records **which must include the MPN name and identification number** to the second opinion physician within 5 business days of being informed of the appointment prior to the appointment date, and provide a copy of the records to the covered employee upon request; and (3) notify the second opinion physician in writing that he or she has been selected to provide a second opinion and the nature of the dispute with a copy to the employee; and provide authorization for the evaluation. If the appointment is not made within 60 days of receipt of the list of the available MPN providers, then the employee shall be deemed to have waived the second opinion process with regard to this disputed diagnosis or treatment of this treating physician.

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

**Commenter recommends adding a new number (7):**

**(a)(7) A reduction in the number of medical providers who have agreed to participate in the MPN by more than 10%.**

**MPN Plan Modification form:**

Add another check box with the following language:

**Change of the number of medical providers in the network which must include an accounting of the medical specialties affected.**

**Section 9767.11 Economic Profiling Policy**

**(**a)(5) add the following new language:

**(5) The MPN shall provide the medical provider with specific information related to the medical provider that they relied upon to deny or to terminate the medical provider’s participation in the MPN.**

**Section 9767.12. Employee Notification.**

**Recommended change is in bold:**

**(a)(2)(B)** A description of MPN services as well as the MPN’s web address for more information about the MPN including how to contact the MPN contact and medical access assistants and information about how to obtain a copy of MPN employee notification as required by regulation 9767.12 and the web address that includes a roster of all treating physicians and the complete statewide listing of all **actively** participating providers in the MPN;

(C) How to review, receive or access the MPN provider directory. An employer, insurer, or entity that provides physician network services shall ensure covered employees have access to, at minimum, a regional area listing of MPN providers in addition to maintaining and making available its complete provider directory listing in writing and/or on the MPN’s website. The MPN’s website address shall be clearly listed. If an employee requests an electronic provider directory listing, it shall be provided electronically on a CD, flash drive, via email on a website. 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. The MPN provider directory shall not be password protected. MPN applicants are responsible for updating 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. Each provider directory 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 directory within 45 days of notice to the MPN through the contact method stated on the provider directory listing to report inaccuracies. The MPN provider directory shall only list **actively** participating providers. The directory shall include, at a minimum, the name of each individual provider and their office address and office telephone number. If the ancillary service is provided by an entity rather than an individual, then that entity’s name, address, and telephone number shall be listed. The MPN provider directory shall list out separately primary treating physicians by name and not by entity in a single searchable list by medical specialty and location.

We would also ask that the Division consider setting up a centralized directory of MPN providers. We imagine that MPNs are already spending a significant amount of money to keep their online medical provider portal and provider directory updated. In fact, we have learned from the larger MPNs that several MPNs already use the same company and on-line platform - Enlyte - to support their on-line medical provider portals.

This money could be pooled and redirected to support the DWC centralized medical provider directory with the MPN sending information to the centralized system. This centralized system would increase transparency, result in increased accuracy and efficiency for all parties, and potentially be less expensive than each MPN maintaining their own online physician portal.

We envision the DWC centralized site would operate as follows:

* MPNs would be required to send DWC a list of all of the active medical providers in their MPN on a specific timeline.
* DWC would post an alphabetical list of all medical providers within all MPNs on their website which would include a list of MPNs that each provider is part of. This would not be password protected to assist providers in referring IWs to network providers.
* The DWC website would have a second password protected level which would allow providers to login to their specific profile. This site would list each MPN that the medical provider is part of, include the name and ID number of the MPN, a description of who is covered under the MPN, and name each PPO network utilized by the MPN. The provider would have the ability to opt-out of any MPN that lists them as part of their network. Providers would have to separately contact the PPO network to opt-out of a PPO network.
* When a provider opts out of the MPN, the DWC site would send an automated message to the MPN letting them know that the provider has opted out of their MPN.
* MPN would be required to take the provider out of their MPN and update their online directory within 30 calendar days.

**9767.16. Medical Provider Network Complaints.**

**Recommend additions are in bold:**

(a) Any person contending a Medical Provider Network is in violation of the requirements of this article or Labor Code sections 4616 through 4616.7 shall submit a written complaint directly **to the Administrative Director** **and** the MPN Contact. **The Division shall create an on-line portal to receive these complaints.**

(1) The written complaint shall provide an explanation to the **AD and** MPN with sufficient detail of the MPN’s alleged violation under this article or any of Labor Code sections 4616 through 4616.7. The written complaint shall include, but not be limited to, the following information:

(a)(2)(3) Within (30) calendar days from the date the complaint was received, the MPN applicant shall respond to the complainant **and report to the Division** by:

(b) If the MPN applicant has not remedied the violation or has not taken reasonable action to remedy the violation within thirty (30) calendar days from the date the complaint was received or the MPN has confirmed in writing it is disputing the complaint and denying there is a violation, the complainant may file a written complaint with the Division of Workers’ Compensation against the MPN. If the complainant can show imminent and serious threat to the health of an injured worker, including but not limited to potential loss of life, limb or other major bodily function, he or she may **treat the injured worker and** file a written complaint with the Division of Workers’ Compensation against the MPN concurrently with the written complaint under subdivision (a) submitted on the MPN.

**Section 9767.18. Random Reviews.**

**Recommended additions in bold:**

(a)(2)(B)(v) A copy of the telephone call logs tracking the calls and the contents of the calls made to and by the MPN medical access assistants and the MPN Contact within a reasonable time period. Call logs shall consist of telephone calls made to and from the MAA or MPN contact, **medical provider, or** Adjuster if acting in the role of the MAA. Call logs shall include the date of the initial call, who called, the nature of the call, when the call was returned and how the matter was resolved. If the matter was addressed through electronic correspondence a log shall be kept of the correspondence in the same manner as the call log.

**9792.5.16: Contract Agreements**

**Recommended additions in bold:**

(a) A health care provider or health facility licensed pursuant to section 1250 of the Health and Safety Code may contract with a contracting agent, employer, or carrier for reimbursement rates different from those in the fee schedule pursuant to Labor Code section 5307.1. **The contract rates must be based on the Official Medical Fee Schedule.**

1. (c) The contracted reimbursement rates must be established through an express written and executed agreement **based on the Official Medical Fee Schedule**. All in the contract. The health care provider or health facility licensed pursuant to section 1250 and the contracting agent, employer, or carrier must be parties to the contract for the reimbursement rate to apply. Implied or verbal agreements regarding pricing are not a basis for a reduction in payment.
2. (f) If there is a **payment** dispute regarding the **contracted** rate versus the official medical fee schedule rate under labor code section 5307.1, the dispute shall be resolved in accordance with Labor Code section 4603.6 **utilizing the Independent Bill Review process. For purposes of Labor Code section 4603.6, a payment dispute includes a contract dispute involving a discount or reduction that was applied to a medical treatment bill. In order to adjudicate the payment dispute, IBR shall request a copy of the underlying contract that the payor relied upon to justify the discount or reduction in reimbursement. The contract shall be provided to the medical provider with the IBR decision. If the payor cannot produce a valid contract justifying the discount or reduction, the independent bill review organization shall award the medical provider payment consistent with the official medical fee schedule**.

**An IBR filed solely to resolve a reimbursement issue, may not be withdrawn by the medical provider. If IBR rules in favor of the medical provider, the IBR filing fee must be refunded to the medical provider and included with the payment for medical services. Failure to include the IBR filing fee with the payment for medical services awarded by IBR, shall result in a fine of $1,000 for each offense**.

We are recommending that the starting point for contract negotiations for treating injured workers must be based on the OMFS. We have seen some contracting agents attempt to base the reimbursement on Medicare rates instead of the OMFS resulting in over a 50% discount for treating injured workers. The contracting agents then also ask for a PPO discount resulting in lower than Medicare rates for treating injured workers. When medical providers realize the impact of these contracts and the low reimbursement rates they are receiving, they drop out of the WC system causing access problems for injured workers. This confusion could be avoided by the Division requiring that the WC contracts’ starting point for reimbursement, must be based on the OMFS rather than Medicare rates.

We believe the above amendments will clarify that PPO discount disputes can be resolved through the existing IBR system.

We also receive complaints from members that:

1) Once the claims adjuster realizes that an IBR has been filed, they pay the disputed medical fee and pressure the medical provider to withdraw the IBR by saying they will no longer receive patient referrals if they go forward with the IBR, so that they do not have to also pay the provider the filing fee. This is unfair and not what was intended under the IBR system. This practice must stop.

2) Also, when the payor pays the additional medical amount awarded by IBR, the payor fails to include the IBR filing fee. They tell providers that the filing fee comes out of some other payor account and cannot be included in their medical payment. This is totally unacceptable. The provider is then left fighting with the payor to receive a reimbursement of the filing fee. Often, they just give up and never get reimbursed for the filing fee.

These practices are unfair and obviously designed to discourage medical providers from filing IBRs. We urge the Division to also address these issues.

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Raul Martinez, Esq. March 5, 2025

Christopher Cramer, Esq.

Cramer & Martinez LLP

We are writing to express our concerns regarding the proposed MPN Regulation changes that would remove the certification requirement for interpreters if interpreter services are included as an MPN ancillary service.  
  
We believe this change would negatively impact injured workers, medical providers, and the interpreting profession. California has historically upheld the importance of certified medical interpreters in ensuring clear and accurate communication within the healthcare setting. We strongly urge the DIR/DWC to maintain the current certification requirement to safeguard the quality of interpreting services and protect the well-being of injured workers.

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Carrie Catena March 5, 2025

The proposed regulations removing interpreter certification requirements if interpreter services are included as an MPN ancillary would harm injured workers, depriving them of meaningful language access and putting their health, well-being and human dignity at risk. California has long recognized the importance of professional medical interpreters in ensuring accurate communication. We urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

We underline, removing interpreter certification requirements if interpreter services are included as an MPN ancillary would have severe consequences. Injured workers would face lower-quality interpretation, increasing the risk of miscommunication, incorrect diagnoses, and improper treatment. Without certification standards, the door would be open for untrained individuals, undermining the professional standards that have been established to protect service users/patients and the system as a whole."

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Dalyla Estevez March 5, 2025

Essential Interpreting

As an employee of an interpreting agency, I am very concerned regarding the removal of certification requirements. The interpreters we schedule to assist on matters have studied and passed the state certification requirements. They have been deemed competent to a standard set by the state. Being able to speak a language and being fluent to a the level of a professional interpreter are too very different things.

It is a blatant disregard of both injured workers and medical providers. I have personally seen it in the real world when Spanish speakers are used in place of a certified interpreter. The complete lack of clear and precise communication is horrifying. I have seen it where what the patient and doctor are telling each other is nowhere near what the "interpreter" is relaying to either. Interpreting is not only a memorization words. It is understanding language, and meaning and then being able to properly convey the meaning between parties.

Would you put your health and safety in the hands of a non-expert in a medical field? If there was a barrier between you and your medical welfare how would that stand with you? Clear and precise communication is required for medical assessment, diagnosis, testing, treatment... If you wouldn't do it to yourself, are you ready to put other people's health and welfare at stake?

Keep in mind, cost cutting and unethical people looking to save a buck are out there a plenty. They would rather save a buck than uphold an ethical professional standard. Many would rather find the cheapest person willing to take an assignment, rather than pay a bit more for a certified interpreter. How will certified interpreters and agencies fare against cheap labor? Why should those who strived for education and certification be thrown aside for cheaper? Is any of this worth the liability?

Please take the time to recall why our state sets certain standards in industries. From private to public, city, county, and state. Certifications are required to keep the public safe. They are a set basic standard set of qualifications. Most industries even require additional training prior to renewal of certification/s to ensure the person continues their education in the field.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Ana B. March 5, 2025

As an individual who works in an interpreting agency, I am deeply concerned regarding the removing of certification requirements.

If interpreter services are included as an MPN ancillary, it will open the door for untrained, unqualified individuals to take over the profession putting both injured workers and the integrity of our work at risk. Without proper training and certification, miscommunication in medical settings will become rampant, leading to incorrect diagnoses, improper treatment, and ultimately, harm to the very people we are supposed to help.

Medical providers rely on us to ensure clear, accurate communication, and without certification standards, they will be left questioning the competency of the interpreters they work with, creating inefficiencies and potential legal liabilities. This decision would also devastate small interpreting businesses like the one I work for, allowing unqualified individuals to flood the industry and devalue the years of training and expertise we have worked so hard to attain. Worse yet, it would invite unethical practices where cost-cutting insurers and agencies prioritize cheap, untrained labor over quality, further eroding our profession.

Working for an interpreting agency is more than just a job— I have the responsibility to provide interpreters to assignments who uphold the highest standards of accuracy, ethics, and professionalism. Stripping away certification requirements not only threatens my livelihood, but also endangers the very people who depend on qualified interpreters to navigate critical medical decisions.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Patricia M. Lyman, State Certified Spanish Interpreter March 5, 2025

As a certified interpreter, I am deeply concerned that removing certification requirements for interpreter services included as an MPN ancillary would compromise both the integrity of our profession and the well-being of injured workers.

Certified interpreters play a vital role in facilitating effective communication between medical providers and patients, safeguarding against dangerous misunderstandings. Without certification standards, medical providers would have no assurance of an interpreter's competency, leading to inefficiencies, compromised patient care, and potential legal liabilities.

Removing certification requirements would not only erode the profession but also create opportunities for unethical practices that undermine the trust patients and providers place in our services. Such a decision would risk allowing untrained, unqualified individuals to provide language services in critical medical settings—where clear, accurate communication is essential to ensuring proper diagnoses, appropriate treatment, and patient safety.

I urge the DIR/DWC to maintain certification requirements to protect the integrity of interpreting services, the livelihoods of qualified professionals, and—most importantly—the health and safety of injured workers.

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Patty Gonzalez, Therapy Coordinator March 5, 2025

Associated Hand Surgeons

As a bilingual staff member at a medical facility, I am worried that removing interpreter certification requirements, if interpreter services are included as an MPN ancillary, will put me and my patients in an unfair and dangerous position. Without trained, certified interpreters, I fear I will be asked to interpret complex medical information - something I am not qualified to do. Medical terminology can be complicated, and one small mistake could lead to miscommunication, incorrect treatment, adverse health outcomes. Patients deserve accurate, professional interpretation to fully understand their care, and I should not be forced into a role I am not trained for. Eliminating certification standards puts both patients and staff at risk, and I urge decision-makers to protect the integrity of medical interpretation by keeping certified professionals in place.

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Gloria Rivera, CHI, CCCI **March 5, 2025**

**Certified Medical and CA Court Interpreter**

**English/Spanish Translator**

I have been a Certified Healthcare Interpreter and Certified Court Interpreter in the State of California since 2010. Additionally, I have served as an interpreter trainer for UCSD Extension, The University of Arizona, and Blue Urpi.

Professional interpreters undergo rigorous training and possess near-native proficiency in both English and their working language. Through complex cognitive processes, we facilitate seamless communication between parties in different languages—a skill that requires specialized training. We adhere to strict ethical guidelines and professional standards to ensure accurate and impartial communication between providers and patients.

Certification is a comprehensive process that evaluates an interpreter’s proficiency in terminology, ethics, standards of practice, and interpreting skills. This process ensures that only qualified professionals provide these essential services, preventing untrained bilingual individuals from taking on roles they are not equipped for. The use of unqualified interpreters can put injured workers' health and livelihoods at serious risk.

Eliminating certification requirements would allow individuals who merely claim to have near-native proficiency, yet lack even the most basic training, to act as intermediaries between patients and healthcare providers. Miscommunication in medical settings can lead to delayed diagnoses, improper treatments, and even loss of life or limb. For injured workers, such delays can prolong recovery and jeopardize their ability to earn a living.

Medical providers depend on certified interpreters to ensure clear and accurate communication with patients who speak a different language, come from diverse cultural backgrounds, and may be unfamiliar with the U.S. healthcare system. Unlike untrained bilingual individuals, certified interpreters are equipped to navigate these complexities in every interaction. Using uncertified interpreters increases the risk of misinterpretation, cultural misunderstandings, and legal liabilities.

I do not understand the rationale behind loosening the requirements for such a critical role. While cost-cutting or simplifying administrative processes may be considerations, they should never come at the expense of an injured worker’s health, safety, or financial stability.

I strongly urge the DIR/SWC to maintain the medical certification requirement to protect the well-being of injured workers.

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Melis Lopez **March 5, 2025**

My name is Melis Lopez, and I am writing to express my serious concerns regarding the potential removal of certification requirements for interpreters within the MPN ancillary services. As a certified interpreter with extensive experience, I believe this change poses significant risks to the well-being of injured workers and the overall integrity of the medical interpreting profession.

The elimination of certification standards would inevitably lead to a proliferation of unqualified individuals providing interpreting services. This lack of training and competency would significantly increase the likelihood of miscommunication during critical medical interactions, resulting in diagnostic errors, inappropriate treatment plans, and potentially, severe harm to patients, and lawsuits.  The reliance placed upon accurate and clear communication by medical providers necessitates highly skilled and certified professionals. Removing certification undermines this crucial element, creating uncertainty for healthcare providers and raising significant concerns about liability.

Furthermore, this decision would have devastating consequences for established, certified interpreters and the small businesses they operate. The influx of unqualified competitors would lead to a devaluation of the considerable investment of time, resources, and expertise required to achieve and maintain professional certification. The resulting competitive landscape would likely prioritize cost-cutting over quality, encouraging the use of untrained individuals and jeopardizing ethical standards within the industry.

The role of a certified interpreter extends beyond a simple job; it is a commitment to upholding the highest standards of accuracy, ethics, and professionalism. Maintaining certification requirements is not merely about protecting the livelihoods of qualified interpreters; it is paramount to safeguarding the health and well-being of individuals reliant on accurate medical communication.

I strongly urge the DIR/DWC to reconsider the proposed change and retain the certification requirement for interpreters within the MPN ancillary services. This action is vital to maintaining the integrity of the profession and ensuring the delivery of safe and effective healthcare to injured workers.

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Rafael Estevez **March 5, 2025**

As not only a State Certified Interpreter, but also an interpreting agency owner, ho works in an interpreting agency, I am deeply concerned regarding the removing of certification requirements.

Would you put your health and safety in the hands of a non-expert in a medical field? If there was a language barrier between you and your medical welfare how would that stand with you? If you wouldn't do it to yourself, are you ready to put other people's health and welfare at stake?

If interpreter services are included as an MPN ancillary, it will open the door for untrained, unqualified individuals to take over the profession—putting both injured workers and the integrity of our work at risk. It is a blatant disregard of both injured workers and medical providers. Without proper training and certification, miscommunication in medical settings will become rampant, leading to incorrect diagnoses, improper treatment, and ultimately, harm to the very people we are supposed to help.

Medical providers rely on us to ensure clear, accurate communication. Without certification standards, they will be left questioning the competency of the interpreters they work with, creating inefficiencies and potential legal liabilities. This decision would also devastate small interpreting businesses like the one I own, allowing unqualified individuals to flood the industry and devalue the years of training and expertise we have worked so hard to attain. Worse yet, it would invite unethical practices where cost-cutting insurers and agencies prioritize cheap, untrained labor over quality, further eroding our profession.

Why does our state set certain certification standards in industries? From private to public sectors, city, county, and state, certifications are required to keep the people safe. They are a standard basic set of qualifications to ensure knowledge and proficiency in the specific certifiable field.

Being a certified interpreter and agency owner is more than just a job- it is a responsibility to uphold the highest standards of accuracy, ethics, and professionalism. Stripping away certification requirements not only threatens my livelihood, but also endangers the very people who depend on qualified interpreters to navigate critical medical decisions.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Enedina Davila **March 5, 2025**

Seen it happen to many, just wrote an agency who prefers Non certified interpreters to do their medicals...results , cases lost in court, reversed, or on appeal! Saves a lot of trouble if they used me...reason? Agency only pays them $45.00 bucks,..crude, unprofessional and very unethical ! !

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Sonya Rama, Certified Medical Interpreter March 25, 2025

D.B.A. Elite Interpreting

I have just become aware of an alarming proposed rule change in language access for injured workers.

As an NBCMI and CCHI certified medical interpreter, I am deeply concerned that removing certification requirements will open the door for untrained, unqualified individuals to take over our profession - putting both injured workers and the integrity of our work at risk. Without proper training and certification, miscommunication in medical settings will become rampant, leading to incorrect diagnoses, improper treatment, and ultimately, harm to the very people we are supposed to help. There is an abundance of research demonstrating that the use of untrained or poorly-trained interpreters threatens the health and safety of patients.

Medical providers rely on us to ensure clear, accurate communication, and without certification standards, they will be left questioning the competency of the interpreters they work with, creating inefficiencies and potential legal liabilities. This decision would also devastate small interpreting businesses like mine, allowing unqualified individuals to flood the industry and devalue the years of training and expertise we have worked so hard to attain. Worse yet, it would invite unethical practices where cost-cutting insurers and agencies prioritize cheap, untrained labor over quality, further eroding our profession. Being a certified interpreter is more than just a job—it’s a responsibility to uphold the highest standards of accuracy, ethics, and professionalism.

Stripping away certification requirements not only threatens my livelihood but also endangers the very people who depend on qualified interpreters to navigate critical medical decisions.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Oscar Valdez**, President March 5, 2025**

**State Certified Interpreters**

Medical providers rely on us to ensure clear, accurate communication, and without certification standards, they will be left questioning the competency of the interpreters they work with, creating inefficiencies and potential legal liabilities. This decision would also devastate small interpreting businesses like mine. Being a certified interpreter is more than just a job—it’s a responsibility to uphold the highest standards of accuracy, ethics, and professionalism. Stripping away certification requirements not only threatens my livelihood but also endangers the very people who depend on qualified interpreters to navigate critical medical decisions.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.  
Interpreter Certification exists to protect the rights and lives of injured workers in California.

What is next? Removing the Certification requirements for court interpreters, attorneys, surgeons, nurses and other professionals in California? Insurance companies and their lobbyists in Sacramento should never be allowed to remove the existing Certification requirements in Worker's Compensation cases in order to dictate the rates that they want to pay for interpreting services at med-legal evaluations. This would be a very clear violation of civil rights in any state  in the United States of America.

The State of California will be facing numerous lawsuits against the DIR/DWC by injured workers in California. I will be very happy to provide my Certified Interpreter services for free in that cause of action.

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Christene Pinter, CMI March 5, 2025

As a certified interpreter, I am deeply concerned that removing certification requirements if interpreter services are included as an MPN ancillary will open the door for untrained, unqualified individuals to take over our profession—putting both injured workers and the integrity of our work at risk.

Without proper training and certification, miscommunication in medical settings will become rampant, leading to incorrect diagnoses, improper treatment, and ultimately, harm to the very people we are supposed to help. Medical providers rely on us to ensure clear, accurate communication, and without certification standards, they will be left questioning the competency of the interpreters they work with, creating inefficiencies and potential legal liabilities. This decision would also devastate small interpreting businesses, allowing unqualified individuals to flood the industry and devalue the years of training and expertise we have worked so hard to attain. Worse yet, it would invite unethical practices where cost-cutting insurers and agencies prioritize cheap, untrained labor over quality, further eroding our profession.

Being a certified interpreter is more than just a job—it’s a responsibility to uphold the highest standards of accuracy, ethics, and professionalism. Stripping away certification requirements not only threatens my livelihood but also endangers the very people who depend on qualified interpreters to navigate critical medical decisions.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Edgar Ugarte March 5, 2025

As a practicing certified interpreter, I am deeply concerned that removing certification requirements if interpreter services are included as an MPN ancillary will open the door for untrained, unqualified individuals to take over our profession—putting both injured workers and the integrity of our work at risk. There are already problems caused by interpreters without proper training and certification, creating  miscommunication in medical settings which could lead to incorrect diagnoses, improper treatment, and ultimately, harm to the very people we are supposed to help.

Medical providers and patients rely on trained, certified interpreters to ensure clear, accurate communication to provide the care needed.  Allowing unqualified individuals to flood the industry and devalue the years of training and expertise we have worked so hard  would invite unethical practices where cost-cutting insurers and agencies prioritize cheap, untrained labor over quality, further eroding our profession.

Being a certified interpreter is more than just a job—it’s a responsibility to uphold the highest standards of accuracy, ethics, and professionalism. Stripping away certification requirements  also endangers the very people who depend on qualified interpreters to navigate critical medical decisions.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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David B. Shafer March 5, 2025

Founder & Certified Interpreter

As a certified interpreter, I am deeply concerned that removing certification requirements if interpreter services are included as an MPN ancillary will open the door for untrained, unqualified individuals to take over our profession—putting both injured workers and the integrity of our work at risk.

Medical providers rely on us to ensure clear, accurate communication, and without certification standards, they will be left questioning the competency of the interpreters they work with, creating inefficiencies and potential legal liabilities.

This decision would also devastate small interpreting businesses like mine, allowing unqualified individuals to flood the industry and devalue the years of training and expertise we have worked so hard to attain. Worse yet, it would invite unethical practices where cost-cutting insurers and agencies prioritize cheap, untrained labor over quality, further eroding our profession.

Being a certified interpreter is more than just a job—it’s a responsibility to uphold the highest standards of accuracy, ethics, and professionalism. Stripping away certification requirements not only threatens my livelihood but also endangers the very people who depend on qualified interpreters to navigate critical medical decisions.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Faith Fogel March 5, 2025

As a certified medical interpreter with four years working at a renowned hospital and several years working independently, I am deeply concerned that removing certification requirements if interpreter services are included as an MPN ancillary will open the door for untrained, unqualified individuals to take over our profession—putting both injured workers and the integrity of our work at risk.

Without proper training and certification, miscommunication in medical settings will become rampant, leading to incorrect diagnoses, improper treatment, and ultimately, harm to the very people we are supposed to help. Medical providers rely on us to ensure clear, accurate communication, and without certification standards, they will be left questioning the competency of the interpreters they work with, creating inefficiencies and potential legal liabilities.

Furthermore, this decision would also devastate small interpreting businesses like mine, allowing unqualified individuals to flood the industry and devalue the years of training and expertise we have worked so hard to attain. Worse yet, it would invite unethical practices where cost-cutting insurers and agencies prioritize cheap, untrained labor over quality, further eroding our profession.

Certified interpreters bear the responsibility to uphold the highest standards of accuracy, ethics, and professionalism. Stripping away certification requirements not only threatens our livelihood but also endangers the very people who depend on qualified interpreters to navigate critical medical decisions.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Sara Bolanos March 5, 2025

I have been working as a certified medical interpreter for nearly 25 years. There have been many changes to the laws concerning language access over the years; but one thing remains certain: without proper communication-access to complete treatment cannot be assured. It may not seem important to you that a man died during an  MRI scan because no interpreter was present to ensure that he had no metal implants-and his pacemaker was not taken into consideration. Or a woman being told her benign cyst was a tumor-because of a bad translation; but these errors happen less with Certified Interpreter’s present.

As a certified interpreter, I am deeply concerned that removing certification requirements if interpreter services are included as an MPN ancillary will open the door for untrained, unqualified individuals to take over our profession—putting both injured workers and the integrity of our work at risk. Without proper training and certification, miscommunication in medical settings will become rampant, leading to incorrect diagnoses, improper treatment, and ultimately, harm to the very people we are supposed to help. Medical providers rely on us to ensure clear, accurate communication, and without certification standards, they will be left questioning the competency of the interpreters they work with, creating inefficiencies and potential legal liabilities. This decision would also devastate small interpreting businesses like mine, allowing unqualified individuals to flood the industry and devalue the years of training and expertise we have worked so hard to attain. Worse yet, it would invite unethical practices where cost-cutting insurers and agencies prioritize cheap, untrained labor over quality, further eroding our profession. Being a certified interpreter is more than just a job—it’s a responsibility to uphold the highest standards of accuracy, ethics, and professionalism. Stripping away certification requirements not only threatens my livelihood but also endangers the very people who depend on qualified interpreters to navigate critical medical decisions.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Carla Cuevas March 5, 2025

Medical interpreters should undergo strict training and certification requirements regarding both skills and ethical practices.  Instead of cuddling ignorance and incompetence, California should create adequate training programs and stringent certification tests to ensure the safety of patients and protect legal procedures.

As a certified interpreter, I am deeply concerned that removing certification requirements, if interpreter services are included as an MPN ancillary, will put at risk both injured workers and the integrity of our work.

Without proper training and certification, miscommunication in medical settings will become rampant, leading to incorrect diagnoses, improper treatment, and ultimately, harm to the very people we are supposed to help. Medical providers rely on us to ensure clear, accurate communication, and without certification standards, they will be left questioning the competency of the interpreters they work with, creating inefficiencies and potential legal liabilities.

This decision would also devastate small interpreting businesses like mine, allowing unqualified individuals to flood the industry and devalue the years of training and expertise we have worked so hard to attain. Worse yet, it would invite unethical practices where cost-cutting insurers and agencies prioritize cheap, untrained labor over quality, further eroding our profession. Being a certified interpreter is more than just a job—it’s a responsibility to uphold the highest standards of accuracy, ethics, and professionalism. Stripping away certification requirements not only threatens my livelihood but also endangers the very people who depend on qualified interpreters to navigate critical medical decisions.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Paul Boutin March 5, 2025

As a certified interpreter and the owner of a small interpreting agency, I am extremely concerned about the potential removal of certification requirements. This change would allow untrained, unqualified individuals to enter our profession, putting both injured workers and the quality of interpreting services at serious risk. Without proper certification and training, miscommunication in medical settings will increase, leading to incorrect diagnoses, improper treatment, and ultimately, harm to the very people who rely on accurate interpretation for their care.

Medical providers depend on certified interpreters to ensure clear, precise communication, and without these standards, they will be left unsure of the qualifications of the interpreters they work with - creating confusion and inefficiencies. Small, independent interpreting businesses like mine would also suffer, as the industry would be flooded with unqualified providers, undermining the years of training and expertise that professional interpreters have worked hard to achieve. Even worse, it could open the door for unethical practices, where large companies and insurers prioritize cost-cutting over quality, further damaging our profession.

Interpreting is not just a job - it carries a responsibility to uphold the highest standards of accuracy, ethics, and professionalism. Removing certification requirements would not only threaten my business but would also compromise the safety and well-being of injured workers. I strongly urge the DIR/DWC to keep certification requirements in place to protect the integrity of interpreting services and ensure that those who need language access receive the highest quality care.

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Cindy Razo March 5, 2025

Associated Hand Surgeons

As an office manager at a busy medical facility, I see firsthand how important professional interpreters are to patient care. Our medical team depends on reliable, certified interpreters to ensure that injured workers understand their treatment, communicate with their doctors, and receive the care they need. When interpreters are not available—or worse, when unqualified individuals attempt to interpret—everything in our office becomes more difficult, leading to delays, frustration, and, most importantly, compromised patient care.

Removing interpreter certification requirements if interpreter services are included as an MPN ancillary would have severe consequences. Injured workers would face lower-quality interpretation, increasing the risk of miscommunication, incorrect diagnoses, and improper treatment. Without certification standards, the door would be open for untrained individuals to flood the industry, undermining professional standards and hurting the small, trusted interpreting agencies we rely on.

Right now, we work with local interpreting agencies that understand our facility’s needs and ensure we have qualified interpreters when we need them. Stripping away certification requirements would threaten the integrity of interpreting services, the well-being of injured workers, and the efficiency of medical care. Certified interpreters are not a luxury - they are a necessity.

I ask the DIR/DWC to keep the certification requirement in place to make sure interpreting services stay reliable and injured workers get the care they deserve.

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Bradley Bowen March 5, 2025

California Certified Medical Interpreter

I have been a certified interpreter since 2008 and I am very worried about removing certification requirements for interpreters that are included as an MPN ancillary service.  Already I have had injured workers tell me many times that they have had "interpreters" who do not speak Spanish fluently. I have also had doctors complain about "interpreters" who were not interpreting accurately or who seemed to have trouble communicating with themselves or their patients. Removing the certification requirement will allow the insurance companies to send untrained, unqualified individuals which will put both injured workers and the integrity of our work at risk. Something they have already been doing to the detriment of injured workers.

Without proper training and certification, miscommunication in medical settings will become rampant, leading to incorrect diagnoses, improper treatment, and ultimately, harm to the very people we are supposed to help. Medical providers rely on us to ensure clear, accurate communication, and without certification standards, they will be left questioning the competency of the interpreters they work with, creating inefficiencies and potential legal liabilities. It would invite unethical practices where cost-cutting insurers and agencies prioritize cheap, untrained labor over quality, further eroding our profession. Being a certified interpreter is more than just a job—it’s a responsibility to uphold the highest standards of accuracy, ethics, and professionalism. Stripping away certification requirements not only threatens my livelihood but also endangers the very people who depend on qualified interpreters to navigate critical medical decisions.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Maria Palacio March 5, 2025

State Certified Interpreter

As a state-certified interpreter since 1993, I am deeply and sincerely concerned that removing certification requirements if interpreter services are included as an MPN ancillary, will open the door for untrained, unqualified individuals to serve as an alleged bilingual provider of communication.

This will absolutely put both injured workers and the integrity of our work at risk. Without proper training and certification, miscommunication in medical settings will become rampant, leading to incorrect diagnoses, improper treatment, and ultimately, harm to the very people that certified interpreters provide communication for.

Medical providers rely on us to ensure clear, accurate communication.  Without certification standards, they will be left questioning the competency of the interpreters they work with, creating inefficiencies and probable legal liabilities.

Removing the requirement that an interpreter be certified, invites unethical practices where cost-cutting insurers prioritize cheap, untrained labor over quality, further eroding the interpreting profession.

Being a certified interpreter is not just a job for me. It is a responsibility to uphold the highest standards of accuracy, ethics, and professionalism.  From day one, I have always taken this responsibility very seriously.

Removing certification requirements not only threatens my livelihood but also endangers the very people who depend on qualified interpreters to navigate critical medical decisions, including doctors attorneys and judges!

I respectfully urge the DIR/DWC to maintain and support the certification requirement to protect the integrity of interpreting services, the well being of injured workers as well as the well being of the entire Workers' Compensation court system.

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Angie Piceno March 5, 2025

CHI Certified Healthcare Interpreter

As a certified interpreter, I am genuinely alarmed by the potential removal of certification requirements, especially if interpreter services are categorized as an ancillary part of the MPN. This could lead to untrained and unqualified individuals infiltrating our profession, jeopardizing both the welfare of injured workers and the integrity of our field. The absence of proper training and certification will likely result in rampant miscommunication within medical environments, culminating in incorrect diagnoses, inappropriate treatments, and ultimately, harm to those we aim to assist. Medical providers depend on us for clear and accurate communication; without established certification standards, they may doubt the competence of the interpreters they engage, leading to inefficiencies and possible legal complications. This change would also have devastating effects on small interpreting businesses like mine, as unqualified individuals could flood the market, undermining the years of training and expertise we have diligently cultivated. Moreover, it would pave the way for unethical practices, where cost-cutting insurers and agencies might opt for cheaper, untrained labor over quality, thereby further degrading our profession. Being a certified interpreter goes beyond mere employment; it is a commitment to uphold the highest standards of accuracy, ethics, and professionalism. Eliminating certification requirements not only threatens my livelihood but also endangers the individuals who rely on qualified interpreters for critical medical decisions.

I strongly urge the DIR/DWC to retain the certification requirement to safeguard the integrity of interpreting services and ensure the well-being of injured workers.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Form Letter from several interpreters:

Manuel Lopez, Certified Court Interpreter March 5, 2025

Pablo De la Puente, Certified Medical Interpréter March 5, 2025

Christina Camero, Certified Healthcare Interpreter March 5, 2025

Gonzalo Campos, State Certified Medical Interpreter March 5, 2025

Miloslava Lucich, Court Interpreter March 5, 2025

Mary Johnston, Certified Healthcare Interpreter-Spanish March 5, 2025

Edgar Cordoba, Certified Medical Interpreter March 5, 2025

Virginia Ochoa March 5, 2025

Jeff Moran March 5, 2025

Francisco Cabral March 5, 2025

Sonia Saad March 5, 2025

Maricela Fernandez, Certified Interpreter March 5, 2025

Guillermo Artigas March 5, 2025

Mikah Dusette March 5, 2025

Janny D. Parrales March 5, 2025

Teresa Wilson-Summerville March 5, 2025

Helena Salvator March 5, 2025

Elena Wilson March 5, 2025

Frida Blum March 5, 2025

Mayra Cardenas March 5, 2025

Claudia Schalesky March 5, 2025

Blanca Hund March 5, 2025

Albert Valdez March 5, 2025

Lilia Ortiz Candela March 5, 2025

Jersahid Lopez March 5, 2025

Lilia Hazlett March 5, 2025

Victor Fridman March 5, 2025

Cindy Di Lando March 5, 2025

Rosela Castillo March 5, 2025

Liliana Sanchez March 5, 2025

Frank Aguayo March 5, 2025

Ana Olivarez-Levinson, CMI March 5, 2025

Fernando Gomez March 5, 2025

Odalys Dominguez March 5, 2025

Karina McMillan-Rea March 5, 2025

Maite Vasquez March 5, 2025

Alvaro Garcia March 5, 2025

David Ordonez March 5, 2025

Carlos A Rodas March 5, 2025

Zonia Fereaud March 5, 2025

Fernando Kellenberger March 5, 2025

Elisa Gonzalez-Garcia March 5, 2025

Ana Isabel Garcia March 5, 2025

Silvia Uribe March 5, 2025

Andrea Pollock March 5, 2025

Lindy Martinez March 5, 2025

Pearl Lancaster March 5, 2025

Janet Casillas March 5, 2025

Flora de Maria Villarreal March 5, 2025

Vanessa M. Wilbat March 5, 2025

Rocio Morales March 5, 2025

Christina Viramontes March 5, 2025

Deborah Velasco March 5, 2025

Ana Davis March 5, 2025

Rosa Trevizo March 5, 2025

Francisco Hulse March 5, 2025

Samuel Pinilla March 5, 2025

Cecilia Tello March 5, 2025

Teresa Y. Mumm March 5, 2025

Lucy Pasternak March 5, 2025

Ramiro Moreno March 5, 2025

Susana Baron March 5, 2025

Alicia Benson March 5, 2025

Maria I. Sears March 5, 2025

Luz Llano March 5, 2025

Germaine Nory March 5, 2025

Nelly Montiel March 5, 2025

Arcelia Alvarez March 5, 2025

Pilar Flores Neary March 5, 2025

Mario A. Rojas March 5, 2025

Chris Martinez March 6, 2025

Sandra Talancon March 6, 2025

Ramona Rodriguez March 6, 2025

Araceli Murphy, CHI March 6, 2025

Gaby Vega March 6, 2025

Pati M Chavez March 6, 2025

Yvette Aeschlimann March 6, 2025

Yesenia March 6, 2025

Alejandra Serrano March 6, 2025

Gabriela Ortiz March 6, 2025

Blanca Olivarez March 6, 2025

Marahy Franco March 6, 2025

Amanda De La Rosa March 6, 2025

By proposing this regulation which denies injured workers the right to a certified interpreter, you are openly acting as a surrogate for the Insurance industry and corrupting the workers comp system even more than it already is.

As a certified interpreter, I am deeply concerned that removing certification requirements if interpreter services are included as an MPN ancillary will open the door for untrained, unqualified individuals to take over our profession—putting both injured workers and the integrity of our work at risk.

Without proper training and certification, miscommunication in medical settings will become rampant, leading to incorrect diagnoses, improper treatment, and ultimately, harm to the very people we are supposed to help. Medical providers rely on us to ensure clear, accurate communication, and without certification standards, they will be left questioning the competency of the interpreters they work with, creating inefficiencies and potential legal liabilities.

This decision would also devastate small interpreting businesses like mine, allowing unqualified individuals to flood the industry and devalue the years of training and expertise we have worked so hard to attain. Worse yet, it would invite unethical practices where cost-cutting insurers and agencies prioritize cheap, untrained labor over quality, further eroding our profession.

Being a certified interpreter is more than just a job—it’s a responsibility to uphold the highest standards of accuracy, ethics, and professionalism. Stripping away certification requirements not only threatens my livelihood but also endangers the very people who depend on qualified interpreters to navigate critical medical decisions.

I urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Jorge U. Ungo, CCHI Language Access Advocate March 5, 2025

Certification Commission for Healthcare Interpreters

I am writing on behalf of the Certification Commission for Healthcare Interpreters (CCHI) to offer comments on the proposed update to Title 8 California Code of Regulations section 9767.3, which would remove the certification requirement for interpreters in Medical Provider Networks (MPNs) and instead rely on minimal qualification standards.

Since its founding in 2009, CCHI has been dedicated to establishing a national, valid, credible, and vendor-neutral certification program. Our certification process is developed with input from interpreters, educators, healthcare providers, industry associations, and advocates for individuals with limited English proficiency (LEP). CCHI is the only healthcare interpreter certification organization accredited by the National Commission for Certifying Agencies (NCCA), which sets rigorous standards for professional certification programs across industries. We have worked with multiple states, including California, Colorado, Oregon, and Washington, to establish standards for medical interpreters. Currently, we have approximately 5,300 certified interpreters nationwide, with over 1,400 Californians either certified or actively in the process of obtaining their certification.

CCHI offers two comprehensive national certification credentials:

● Certified Healthcare Interpreter™ (CHI™) – A bilingual performance-based certification for Arabic, Mandarin, and Spanish interpreters.

● Core Certification Healthcare Interpreter-Performance™ (CoreCHI-Performance™) – Available to interpreters of all other languages, this certification includes an English-to-English™ (ETOE™) interpreting exam, validated through national research and psychometric analysis, ensuring equitable assessment across languages.

We want to bring to your attention some concerns that we have about the proposed update to Title 8 California Code of Regulations section 9767.3. The proposed removal of certification requirements poses significant risks across multiple dimensions:

● Protecting Injured Workers - Removing certification requirements compromises patient care and increases the likelihood of harmful miscommunication. Certified interpreters ensure accurate communication between medical providers and injured workers, reducing the risk of misdiagnosis, improper treatment, and extended recovery times.

● Safeguarding Medical Providers - Inaccurate interpretations can lead to medical errors, placing both patients and providers at risk. Without certification standards, providers face increased administrative burdens, legal liabilities, and uncertainty about interpreter qualifications.

● Upholding Professional Integrity - Certification maintains high standards through rigorous training, testing, and continuing education. Eliminating these requirements undermines professionalism, floods the industry with unqualified providers, and threatens small, independent interpreting businesses—many of which are minority- and women-owned.

● Preventing Exploitation and Fraud - Lack of certification opens the door to cost-cutting practices by insurers and language service providers, leading to lower pay, unethical hiring, and reliance on unqualified interpreters, including untrained bilingual staff or family members.

CCHI strongly opposes this change, as it poses risks to patient safety, increases liability for medical providers, and undermines professional standards. Certification ensures interpreters meet rigorous qualifications, protecting injured workers from miscommunication and improper care. Additionally, removing certification requirements could lead to the exploitation of interpreters and the hiring of unqualified individuals.

Maintaining certification requirements is essential to safeguarding injured workers, supporting medical providers, and preserving the integrity of the interpreting profession. We urge the DWC Rulemaking Committee to uphold the certification requirement in the interest of patient safety and professional standards.

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Robyn Calvetti, Provider Network Manager March 4, 2025

EK Health Services

# 9767.3 Requirements for a Medical Provider Network Plan

(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. Telehealth only providers shall not be considered in the access standards calculation for the MPN application as they do not meet the requirements of Business and Professions code section 2290.5. A judge or the Workers’ Compensation Appeals board may consider telehealth only providers in a determination as to access standards. 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.

*Many MPN Psychologists and Psychiatrists treat only via Telehealth and have since 2020. Not being able to include these specific telehealth only providers in our access standards calculations will mean we will not meet access in a large number of zip codes. We would like to suggest allowing certain specialties, like Behavioral Health, that mainly treat via Telehealth be allowed to be counted in access calculations.*

# 9767.5 Access Standards

d) A workers’ compensation judge or the Workers’ Compensation Appeals Board may determine that an injured worker may seek treatment outside the MPN if the MPN does not have at least 3 primary treating physicians from a different medical practice group.

*Looking for clarification on if ‘different medical practice group’ means facility or address. We would want to be able to count at least one PTP at each address when they are working within the same organization but within the required access standards.*

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Tina de la Guerra March 4, 2025

Associated Hand Surgeons

The proposed regulations removing interpreter certification requirements if interpreter services are included as an MPN ancillary would harm injured workers, medical providers, and the interpreting industry. California has long recognized the importance of professional medical interpreters in ensuring accurate communication. We urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers

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Elizabeth Fitz, Claims Technical Specialist March 4, 2025

Sentry Insurance

**Section 9767.3.** **Requirements for a Medical Provider Network Plan. (Pages 11 – 13)**

* (8)(E) – Please clarify if “telehealth” can be listed for physicians who offer telehealth services along with other specialty services at brick-and-mortar locations or can it only be listed for physicians that only provide telehealth services. For example, brick and mortar physician records would list the word “telehealth” within their specialties but the telehealth only physician record would list the words “telehealth only”.
* (8)(J) – Please clarify if “remote service” can be listed for ancillary services who offer remote services along with other services at brick-and-mortar locations or can it only be listed for ancillary services that only provide remote services. For example, brick and mortar ancillary services would list the words “remote services” but the ancillary services who only provide remote services the words “remote services only”.
* (8)(T) – Please clarify which website(s) this information shall be provided on. The MPN website or the provider directory/search website (web address or URL) containing the Roster of Treating Physicians and Roster of Ancillary services.

Section 9767.4. Cover Page for Medical Provider Network Application or Plan for Reapproval (Page 16)

* On the Cover Page for Medical Provider Network Application or Plan for Reapproval could the physical location address also be included in addition to the DWC PO Box as certain forms of mailing require actual street address/physical location?

Section 9767.5. Access Standards. (Page 19)

* Please clarify 5 days – is this business days or calendar days?
* (2) Please clarify 5 days – is this business days or calendar days?

Section 9767.6  Treatment and Change of Physicians Within MPN (Page 23)

* (f) Please clarify 20 days – is this business days or calendar days? Gathering of all medical records including diagnostic and laboratory tests within a 20 calendar day period may be too limited of a timeframe, for receipt of related medical records, preparing and delivering the records/results to the selected treating physician.

Section 9767.7. Second and Third Opinions (Pages 24-25)

* (b) and (d) Request that prior wording in the language (“prior to the appointment date”) be retained. If the records are required to be sent to the second or third opinion providers within 5 business days of being informed of the scheduled appointment but the scheduled appointment is scheduled further in the future there could continue to be subsequent treatment/testing occurring during that time. Those records would then be a subsequent submission.

Section 9767.8. Modification of Medical Provider Network Plan (Pages 26 and 31).

* (3) The MPN Liaison is removed from the requirements of when a modification needs to be filed. There still is a requirement to file a modification if the Authorized individual changes however on the actual form (page 31) the check box was stricken in its entirety. There should be a check box that indicates “Change of Authorized Individual”.

Section 9767.19. Administrative Penalty Schedule; Hearing, Mitigation and Appeal (Pages 51 and 52)

* (1) (I) Please clarify if number of days within this section are business days or calendar days.
* (2) (E) Request that the wording “or offer” remain within the regulations. If the injured covered employee does not accept a scheduled appointment within this timeframe this is out of the MPN Medical Access Assistant control.

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Susan Randolph, Corporate Secretary March 4, 2025

Executive Linguist Agency, Inc.

Comment from an agency with forty-seven years of experience providing interpreting and translation services for many work comp carriers.

Those companies who choose to include an interpreting service in their MPN without verifying that the service is in fact providing professional and reliable interpreters are not saving themselves any money.

It is costly to have claim handlers spending time dealing with no-interpreter-showed-up emergencies and consequences.

Litigated cases are more expensive than those where treatment proceeds smoothly and effectively because the claimants understand the process and are confident their needs are recognized.

Remember It is the stingy man who pays the most.

The regulators would be doing those companies seeking to cut corners on the backs of interpreters a favor by requiring their MPN's to use certified interpreters.

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Alex Rossi, Manager, CEO March 4, 2025

Risk Management

The below proposed penalty regulation (9767.6(h)) is problematic as it will increase litigation, expense, and WCAB resource needs.

* The regulation fails to define an unreasonable “delay as a result of the MPN’s failure to act.”
* The regulation promotes an administrative penalty that is assessed by a workers’ compensation judge or the WCAB increasing the burden on a resource drained agency.
* The regulation opens the door to attorney fees under LC 5813(a) increasing litigation expense in a workers’ compensation system whose major cost is allocated and unallocated expense rather than benefits to injured workers.
* The regulation will require the Medical Provider Network to hire an attorney to defend allegations submitted to the WCAB creating additional litigation friction.
* The regulation will require significant investigation to determine whether treatment was unreasonably delayed and if the delay was caused by a failure to act on the part of the Medical Provider Network.
* The regulation has the potential to become weaponized and increase costly shenanigans.

9767.6(h) If a workers’ compensation judge or the Workers’ Compensation Appeals Board determines that authorization for treatment with a MPN provider is unreasonably delayed, a penalty of $1,000 shall be assessed. This penalty shall be treated as a separate species of penalty under Labor Code 5814(e) and may be appropriately assessed at trial, including Expedited Hearings pursuant to Labor Code 5502(b)(1). If a workers’ compensation judge or the Workers’ Compensation Appeals Board determines that authorization for treatment with a MPN provider is unreasonably delayed as a result of the MPN’s failure to act an administrative penalty may issue in accordance with regulation section 9767.19(a)(1)(G) against the MPN. The workers’ compensation judge or Workers’ Compensation Appeals Board shall determine the cause of the delay and make and serve a specific finding on the Division of Workers Compensation at the time of decision finding an unreasonable delay.

Though proposed regulation 9792.5.16 is well intended, some of the provisions require clarification.

Proposed regulation 9792.5.16(c) reads, in part, the following: The health care provider or health facility licensed pursuant to section 1250 and the contracting agent, employer, or carrier must be parties to the contract for the reimbursement rate to apply.  As presented, and based on the serial comma, it appears the contracting agent can be party to the contract and the benefit of the negotiated reimbursement rate extends to their client (employer/carrier).  Is this true?

Under proposed regulation section 9792.5.16(d), there is an expressed requirement that the contract between the contracting agent and the healthcare provider/facility list the specific employer or carrier subject to the Medical Provider Network.  The difficulty arises when a contracting agent (PPO/MPN) adds or deletes clients.  In those situations, will a contract amendment be required as clients to the PPO/MPN provider are added and deleted?

Currently, the explanation of review contains the name of the PPO/MPN and PPO/MPN ID number if a PPO/MPN reduction is applied to the charges.  This affords the medical provider/facility to verify a contract exists with the PPO/MPN.  If the reason for the proposed regulation relates to silent PPO or leased network agreements, mandating licensing provisions are consistent with those established under Health and Safety Code 1395.6 could resolve that issue.  This could be accomplished by amending proposed 9702.5.16(c) as follows below and deleting 9702.5.16(d) entirely.

The contracted reimbursement rates must be established through an express written and executed agreement. All terms regarding pricing and reimbursement rates must be explicitly stated in the contract. The health care provider or health facility licensed pursuant to section 1250 and the contracting agent, employer, or carrier must be parties to the contract for the reimbursement rate to apply. Implied or verbal agreements regarding pricing are not a basis for a reduction in payment. *All contracts under which a reimbursement rate is claimed shall comply with the provisions established under Health and Safety Code 1395.6.*

Finally, proposed regulation 9792.5.16 is premature.  Any regulation related to PPO/MPN contracts should mirror AB 1048 (Chen) whose intent is to enact legislation to improve transparency and accountability in contracts between payers and medical providers in the workers’ compensation system.

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Miranda Freitas Condra, Esq. March 4, 2025

Minale Law Group, APC

I strongly oppose the proposed amendment that eliminates the requirement for interpreters within an MPN’s ancillary service to be certified and instead defers to the outdated and inadequate certification standard under Labor Code § 4600(g) and the Administrative Director’s (AD) rules. This change significantly weakens the protections for injured workers and effectively prioritizes cost-cutting over language access and patient care.

Under existing AD rules, claims administrators can designate someone as a “provisionally certified” interpreter, regardless of whether they meet legitimate certification requirements. In practice, this loophole is routinely exploited, allowing non-certified interpreters to be used simply because they are cheaper, at the direct expense of injured workers’ rights and accurate medical evaluations. The proposed regulation update further legitimizes this problematic practice by failing to mandate the use of truly qualified interpreters.

By allowing MPNs to sidestep the requirement for certified interpreters, the proposed language directly undermines due process and medical integrity. Medical treatment and evaluations rely on precise communication, and the use of underqualified or unqualified interpreters can lead to misdiagnoses, improper treatment, and inaccurate disability assessments. Injured workers—particularly those with limited English proficiency—deserve better.

Rather than reinforcing outdated and insufficient standards, the regulation should instead explicitly require that all interpreters used for medical treatment, evaluations, and medical-legal examinations be fully certified under current, recognized certification programs. The proposed update provides an opportunity to strengthen, not weaken, interpreter qualifications in the MPN system.

I urge the Division to delete the references to Labor Code § 4600(g) and the AD’s rules regarding provisional certification and instead require compliance with the recognized certification standards for medical examinations and evaluations. This will ensure injured workers receive competent interpretation services, preserving the accuracy of medical treatment and reports that form the basis for benefits decisions.

The integrity of California’s workers’ compensation system depends on the use of qualified professionals at every stage, including interpreters. Any regulation that facilitates the use of unqualified interpreters should be rejected outright**.**

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Kenneth D. Martinson-Gomez March 4, 2025

Abogado Gomez

The Court would deny Applicant Language Access and Due Process within the Workers’ Compensation System by basing an Award on Dr.  report that demonstrates prejudice against Applicant’s membership in a Protected Class, i.e. Spanish-speaking. The Spanish-Speaking applicant has an absolute right to Due Process. Rucker v. Workers’ Comp. Appeals. Bd. (2000) 82 Cal.App.4th 151, 157-158. Due Process requires the enforcement of language rights and language access. Govt Code 68560(e).

The Court is obligated to respect language rights and the national origin of the Applicant. Govt Code 11435.05.  The Court would not respect those rights should they deem Dr.  report substantial and impartial.  National Origin discrimination in the form of Language Discrimination is not allowed as it violates Equal Protection. Skip Fordyce, Inc., Workers’ Comp. Appeals Bd. (Barry) (1983) 48 Cal.Comp.Cases 904.

The Court is a state agency that owes a duty to Spanish-speaking Applicants to provide “equal justice … for their special needs” in the “administrative law system.” Govt Code 68560(e) [edited]. The Court can not discriminate against an Applicant based on National Origin. Govt Code 11135. The Civil Rights Department defines National Origin as the individual’s “actual or perceived … linguistic characteristics associated with a national origin group.” CCR, tit. 2, div. 4.1, chapter 5, subchapter 2, art. 4, Sect. 11027.1. [edited] Applicant speaks Spanish and is part of a National Origin group.

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Jason Schmelzer, Managing Director March 4, 2025

Ashley Hoffman, Senior Policy Advocate

Faith Borges, Legislative Advocate

Our members have a variety of concerns with proposed Section 9792.5.16 on Contract

Agreements:

- Section 9792.5.16(c), (d), and (e) would create new regulatory standards for valid

contracts. Has the DWC evaluated whether these new requirements would

invalidate existing contracts with providers and the potential impact? We would urge

DWC to proceed with caution to the extent that this provision might invalidate or call

into question the validity of a considerable number of existing provider contracts.

- Section 9792.5.16(f) would require all disputes over the applicability of medical

provider contracts to be resolved via the Independent Bill Review (IBR) process

established in Labor Code Section 4603.6. We do not support this idea for two

reasons.

First, many of the contracts in question have binding provisions related to dispute

resolution. These provisions can include internal appeals processes, arbitration,

and/or selection of venues for resolving disputes. In fact, Labor Code Section

5275(b) specifically allows parties in the workers’ compensation system to agree to arbitration to resolve disputes. The proposed regulations would conflict with

statutorily authorized arbitration agreements in contracts as drafted.

Second, we are concerned that the IBR process is not designed to resolve these

types of disputes. The IBR process is not staffed by attorneys or judges that are

appropriately trained to resolve sometimes complicated questions of contract law

or subject matter jurisdiction. Unless this proposal anticipates a significant

retooling of the IBR process, we do not see how this proposal is workable.

We are also concerned with the new penalty provisions contained in the proposal. We

believe that the penalty provisions seem excessive for what generally amount to clerical paperwork errors. In addition, the $1,000 per instance penalty in Section 9767.19(a)(2)(G) is not only excessive but also appears to be duplicative of penalty provisions in Labor Code Sections 4650, 5813, and 5814. We recommend that the DWC remove the proposed new penalty provisions or rework them to be more reasonable and less duplicative of existing penalty provisions.

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Olivia Singler, President March 4, 2025

Northern CA Translators Association

**COMMENT:**

We oppose removing the following from CCR 9767.1 section (c)(3)(6):

“*If interpreter services are included as an MPN ancillary service, the interpreters listed must be certified pursuant to section 9795.1.6(a)(2)(A) and (B)” from CCR 9767.1 section (c)(3)(6).”*

We oppose adding the new requirement for interpreters to be certified in CCR 9767.1 section (c)(3)(6):

*“ (7) … as provided for in Labor code section 4600(g) and the Administrative Director’s regulations regarding interpreter services.”*

**REASON:**

Eliminating the certification requirement for interpreters in Medical Provider Networks (MPNs) and instead relying on the minimal qualification standards outlined in Labor Code Section 4600(g) – which references the outdated California Health and Safety Code §1367.04 – would have devastating consequences for injured workers, medical providers, and the small businesses that sustain California’s interpreting industry.

Relying on the Administrative Director’s regulations, which include permitting claims administrators to “provisionally certify” persons to serve as interpreters, would have equally devastating consequences for several key reasons:

1. Harm to Injured Workers

• Lower-Quality Interpretation: Without certification requirements, unqualified individuals could serve as interpreters, leading to inaccurate communication between doctors and injured workers. Misinterpretations can result in incorrect diagnoses, improper treatment plans, and prolonged recovery times.

• Compromised Patient Care: Certified interpreters are trained in medical terminology and ethical standards, ensuring that injured workers fully understand their medical conditions and treatment options. Removing certification requirements increases the risk of miscommunication, which could jeopardize patient outcomes.

2. Burden on Medical Providers

• Increased Administrative Challenges: Medical providers rely on certified interpreters to facilitate clear communication. Without certification standards, they would have no assurance that the interpreter provided is qualified, forcing them to spend additional time verifying competency or dealing with miscommunication issues.

• Legal and Liability Risks: If an unqualified interpreter provides inaccurate information leading to medical errors, medical providers could face liability concerns, creating additional legal risks for doctors and clinics treating injured workers.

3. Devastation to Small Interpreting Businesses

• Undermining Professional Standards: California’s certified interpreters undergo rigorous training, testing, and have continuing education requirements. Allowing unqualified individuals to act as interpreters undercuts the value of certification and disincentivizes professional standards.

• Market Saturation by Unqualified Providers: Eliminating certification requirements would open the door for untrained individuals to flood the industry, making it harder for certified interpreters and small agencies to compete. Many independent, minority- and women-owned interpreting businesses would struggle to survive against low-cost, unqualified providers.

4. Exploitation and Fraud Risks

• Rise in Unethical Practices: Without certification requirements, insurance companies and large language service providers could hire unqualified interpreters at lower rates, prioritizing cost savings over quality service.

• Potential for Abuse: Some medical providers might resort to relying on bilingual staff or family members as interpreters, even if they lack the necessary skills to accurately translate complex medical information.

**RECOMMENDATION:**

Instead of removing the certification requirement for interpreters in MPNs, the DIR/DWC could instead further strengthen protections for limited English Proficient (LEP) injured workers by updating this MPN regulation to align with current language access standards.

The language in 8 CCR §9767.3(c)(3)(6) could be improved to include all the types of credentialed interpreters who are qualified to serve as professional interpreters pursuant to existing regulations as follows:

*If interpreter services are included as an MPN ancillary service, the interpreters listed must hold active certification through: (i) The Judicial Council of California as a Certified Court Interpreter or Registered Interpreter in good standing; (ii) The California Department of Human Resources (CalHR) Medical and Administrative Hearing Interpreter Certification; (iii) The Certification Commission for Healthcare Interpreters (CCHI) as a Certified Healthcare Interpreter (CHI™ ) or Core Certification Healthcare Interpreter (Core-CHI-P™); or (iv) The National Board for Certification of Medical Interpreters (NBCMI) as a Certified Medical Interpreter (CMI).*

Keeping the proposed amendments to §9767.3(c)(3)(6) would severely harm injured workers, burden medical providers, and threaten the livelihoods of professional interpreters and small businesses. California has recognized the importance of professional medical interpreters since the early 1990’s in ensuring accurate, high-quality communication in medical settings. Don’t turn back the clock now.

We urge the DIR/DWC rule makers to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

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Lina Avidan March 3, 2025

"The proposed regulations removing interpreter certification requirements if interpreter services are included as an MPN ancillary would harm injured workers, depriving them of meaningful language access and putting their health, well-being and human dignity at risk. California has long recognized the importance of professional medical interpreters in ensuring accurate communication. We urge the DIR/DWC to maintain the certification requirement to protect the integrity of interpreting services and the well-being of injured workers.

We underline, removing interpreter certification requirements if interpreter services are included as an MPN ancillary would have severe consequences. Injured workers would face lower-quality interpretation, increasing the risk of miscommunication, incorrect diagnoses, and improper treatment. Without certification standards, the door would be open for untrained individuals, undermining the professional standards that have been established to protect service users/patients and the system as a whole."

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Stacy Leal, CA MPN Manager, Corvel February 27, 2025

I would like to comment on the section of proposed language for 9767.6

(f) The insurer or employer shall deliver to the initial primary treating MPN physician selected by the employee, within twenty (20) days of notice of selected physician, all relevant medical records relating to the claim, if any, including the results of diagnostic and laboratory testing done in relation to the injured employee's treatment. The insurer or employer shall advise any subsequently selected MPN physician that any medical record or diagnostic and laboratory test result deemed relevant by that provider will be delivered upon request. The insurer or employer shall also advise all selected MPN physicians of the relevant MPN identification number, name, telephone number, fax number, email address, and mailing address of the person or entity to whom a request for authorization and bills should be sent.

What if the insurer or the employer send a copy of the Complete Written Employee MPN Notice for the MPN that the injured worker participates in.  This will allow them to see instructions on how to access the directory or login to the directory?

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Stacy Leal, CA MPN Manager, Corvel February 27, 2025

I am writing to comment on pg. 23 - 9767.6 (h)

(h) If a workers’ compensation judge or the Workers’ Compensation Appeals Board determines that authorization for treatment with a MPN provider is unreasonably delayed, a penalty of $1,000 shall be assessed. This penalty shall be treated as a separate species of penalty under Labor Code 5814(e) and may be appropriately assessed at trial, including Expedited Hearings pursuant to Labor Code 5502(b)(1). If a workers’ compensation judge or the Workers’ Compensation Appeals Board determines that authorization for treatment with a MPN provider is unreasonably delayed as a result of the MPN’s failure to act an administrative penalty may issue in accordance with regulation section 9767.19(a)(1)(G) against the MPN. The workers’ compensation judge or Workers’ Compensation Appeals Board shall determine the cause of the delay and make and serve a specific finding on the Division of Workers Compensation at the time of decision finding an unreasonable delay.

My comments:

* I think that saying the “MPN applicant” instead of just MPN would add clarity.
* I believe the reference to 9767.19 (a)(1)(G) should instead be 9767.19 (a)(2)(G)

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Darrell DeMoss, Compliance Officer **- MedRisk February 17, 2025**

The proposed revision adds language defining “Contracting Agent” in Section 9767.1(2) and in Section 9792.5.15(b).  This definition generally is taken from Cal Labor Code Section 4609 and usefully attempts to define the term “preferred provider organization” by referencing existing regulation.

The regulatory citation, however, is inaccurate.  There is no “title 8 California Code of regulations section 4610.”  Further, Labor Code Section 4610, which might have been the intended reference, addresses utilization review and does not include a definition of “preferred provider organization.”

Fortunately, a very helpful definition of "preferred provider organization” can be found at Cal Insurance Code Section 10192.10(b)(10):

**(10)** “Preferred provider organization” means a health care provider or an entity contracting with health care providers that (A) establishes alternative or discounted rates of payment, (B) offers the insureds certain advantages for selecting the member providers, or (C) withholds from the insureds certain advantages if they choose providers other than the member providers. Organizations regulated as Medicare Select include, but are not limited to, provider groups, hospital marketing plans, and organizations that are formed or operated by insurers or third-party administrators.

Defining “preferred provider organization” in the revised MPN regulations adds important clarity to the DWC’s scope of regulation.  Certain provider associations have brought litigation against PPOs claiming that, by establishing alternative or discounted rates of payment below OMFS, they are engaging in fraudulent referral schemes in violation of California’s Unfair Competition Law.

The current draft of the proposed revision to the MPN regulations could be corrected by substituting Insurance Code Section 10192.10(b)(10) for the inaccurate reference to 8 CCR 4610 or by adding a new definition to the text of the revised MPN regulations, using the relevant provisions of the definition found in Cal Insurance Code Section 10192.10(b)(10).

1. 1 For example, see Section 9767.13.(c), which requires an MPN applicant to request a reevaluation of a denied MPN application “within 20 days of the issuance of the Notice of Disapproval”. There could be a significant lag time between “issuance” and receipt/review. For consistency’s sake, it would be preferable if all timelines for response ran from receipt. [↑](#footnote-ref-1)
2. We were unable to find the definitional reference to “Preferred Provider Organization” cross-referenced as occurring in “title 5 California Code of regulations section 4610”. We are assuming that perhaps this was cited incorrectly. [↑](#footnote-ref-2)
3. We have been working with a stakeholder group to help devise ways to improve transparency in the system for providers. [↑](#footnote-ref-3)
4. As mentioned previously, we have been working with a stakeholder group to improve transparency in the system. The group was exploring having the claims examiner provide a portion of the Complete Employee Notification (with MPN identifying information) to providers upon request, with a goal of helping a provider to know which MPN a given injured worker is associated with. [↑](#footnote-ref-4)
5. This is another issue that has been discussed by the stakeholder group; to allow providers to get updated information about their MPN participation status, and to have the ability to “opt in/out” (as appropriate) of MPN’s that they are qualified to participate in. We are willing to work with the DWC to develop regulatory language related to implementation of this idea but requiring additional written acknowledgements only further cements an outdated and inefficient process for both the MPN’s and providers. [↑](#footnote-ref-5)
6. What we are trying to avoid is bombarding the providers with medical records and/or notices that they do not want or need. [↑](#footnote-ref-6)
7. We would be appreciative if consistent terminology could be used throughout the rules to refer to the MPN contact with the DWC. We suggest use of “MPN Liaison” and suggest that all references to such individual be updated accordingly. [↑](#footnote-ref-7)
8. In our stakeholder group, we were told that there were some situations wherein an MPN provider might wish to review their own listing, and that desire was the impetus for the request to remove password protection. We have attempted to devise a compromise solution to provide third party access when needed without requiring costly IT system changes. [↑](#footnote-ref-8)
9. We have noticed that the most common scenario when this occurs is in a situation where a plan submitted its reapproval application, but the DWC was unable to start the “iterative” communication process described above until a relatively short timeframe prior to the expiration of the 180-day period. We have noted (and appreciated) the DWC’s efforts to work with MPN applicants during this process, so this language is unnecessarily limiting. [↑](#footnote-ref-9)
10. There is no existing statutory authority to impose this requirement upon payors in Workers’ Compensation. In fact, in the 2024 legislative session, SB1369 was passed addressing a similar topic with respect to dental providers in the commercial health space, clearly showing the need for a statutory change if this is shown to be an issue warranting intervention. [↑](#footnote-ref-10)
11. As defined by the California Office of the Small Business Advocate (CalOBSA). [↑](#footnote-ref-11)
12. As currently drafted, the proposed CCR 9767.6(f) only mentions “insurers” and “employers” without mentioning “claims administrators.” Other parts of the proposal appear to use these three terms interchangeably. We recommend simply using the term “claims administrators” since it is a catch-all term that includes any entity responsible for administering a Workers Compensation claim. [↑](#footnote-ref-12)
13. The term “contracting agent” is currently defined in Labor Code 4609(d). The proposal includes a new definition in CCR 9767.1(a)(2), though it appears to contradict the statute and risks causing confusion. We recommend using a consistent definition for the term. [↑](#footnote-ref-13)
14. See the Legislature’s bill analysis of Senate Bill 863 (2012), which is publicly available at [http://leginfo.legislature.ca.gov.](http://leginfo.legislature.ca.gov/) [↑](#footnote-ref-14)
15. See the Legislature’s bill analysis of Senate Bill 537 (2019), which is publicly available at [http://leginfo.legislature.ca.gov.](http://leginfo.legislature.ca.gov/) [↑](#footnote-ref-15)