A Promise Unkept

A Targeted Reform Agenda for California Workers’ Compensation

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Executive Summary

This paper starts from a simple premise. California's workers' compensation system is not a gratuity. It is the consideration promised in exchange for the worker's surrender of the right to sue the employer. When the system withholds care, delays treatment, or makes specialist access illusory, it is not merely inefficient. It is failing to deliver the bargain.

The central diagnostic is structural. The problem is not that every stakeholder is acting in bad faith. The problem is that the architecture rewards friction, obscures accountability, and makes it too easy for the minority of bad actors in every stakeholder class to impose costs on everyone else. The response therefore has to be architectural, not merely punitive.

The quality reforms proposed here do two things. First, they create a Qualified Medical Treater credential so that physicians who treat injured workers are trained in the actual substantive and procedural requirements of California workers' compensation. Second, they build an educational quality framework for QMEs and QMTs so that the system verifies quality instead of assuming it.

The access reforms address the specialist shortage at its source. The current MPN architecture is not credible as proof of access because the lists are unreliable and the economics repel specialists. This paper proposes replacing MPNs with a statewide QMT list maintained by DWC, preserving curated networks through a separate Preferred Provider Network layer, and confronting the economic distortion created by opaque PPO discounting in workers' compensation.

The treatment-authorization reforms are equally direct. Where objective decision criteria already exist, they should become operative. IMR should function as a real appellate check rather than a concurrence mechanism. And QME opinions on medical necessity should be admissible as substantive medical evidence, because the deepest clinical review in the system should not be walled off from the very treatment questions the system must answer.

This is not a finished regulatory package. It is a disciplined architectural agenda. The parameters are open to calibration. The commitments are not. If California is serious about honoring the bargain made with injured workers, it has to rebuild the parts of the system that now make quality, access, and timely treatment too difficult to obtain.

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Companion Document: This submission is supported by a comprehensive compendium documenting the diagnostic evidence, methodology, and architectural reasoning behind the reforms proposed below. The compendium is referenced throughout this submission as the documentation infrastructure for any reader who wants to verify, challenge, or further develop any specific reform.

The Grand Bargain

One hundred and ten years ago, California's working people made a trade. The injured worker surrendered the right to sue the employer. Permanently. Irrevocably. Across generations not yet born. In exchange, every working person in the state was promised something specific: medical care for the work-related injury, wages replaced during recovery, compensation for any lasting impairment, and restoration of the ability to earn a living. No fault required. No litigation required. As a matter of right.

That promise is not being kept.

It is worth remembering what the worker gave up, because most of California has forgotten. The right to sue in tort is not a small thing. Outside the workplace, every citizen still has it. The injured pedestrian, the patient harmed by malpractice, the consumer wronged by a defective product, each retains the right to a jury trial, the right to argue for the damages a jury will award, the right to choose their own physician and direct their own care, the right to pursue policy limits and, where conduct warrants, punitive damages. Personal injury settlements routinely range into the hundreds of thousands of dollars and beyond. Those rights, in the rest of American life, are recognized as substantial. They are recognized as valuable. They are recognized as constitutionally protected.

The injured worker gave them up. Not as a gift. Not as charity in either direction. As consideration in a bargain.

When the system fails to deliver what was promised in exchange, the failure is not merely a service gap. It is the confiscation of something the worker paid for in full. The worker paid in advance, with the surrender of their constitutional right of access to the courts, for benefits the system has not delivered. To withhold the consideration owed under a bargain that has already been struck is, at its core, taking. The legal vocabulary and the human vocabulary land in the same place.

The injured worker is not a beggar. The injured worker is not a welfare cheat. The injured worker is not making an entitlement claim out of nowhere. The injured worker is a creditor, collecting on a debt the state imposed on the employer in 1914 in exchange for the worker's surrender of a right of substantial value. The reference frame for evaluating what the worker is owed is not other no-fault administrative systems. The reference frame is what the worker would have if the bargain had never been struck, the personal injury system, with its costs, its

uncertainty, its juries, and its policy-limits settlements. The complaint that workers' compensation is expensive should be measured against that reference frame, not against the cost of doing nothing. Compared to what the worker surrendered the right to pursue, the consideration the worker is owed under the bargain is not extravagant. It is what was promised in exchange for something more valuable.

The reforms in this paper are not asking the system to be more generous. The reforms are asking the system to deliver the consideration that has already been bought and paid for. The promise was made. The promise must be kept.

The Operating Principle

This paper proposes structural reform. Some of what it proposes can be implemented through existing regulatory authority. Some requires formal regulatory change with public comment. Some requires statutory amendment. The author offers no apology for any of these.

Laws are made. Laws are changed. New laws are written when existing laws no longer serve the people they were enacted to protect. California workers' compensation, as the system currently operates, no longer delivers the consideration the bargain promised. The reforms in this paper identify what should change and propose how. Where current statute supports the architecture, the architecture is implemented within it. Where current statute does not, the recommendation is to amend the statute.

The reader who would respond that the paper is unrealistic because parts of it require legislative change is not engaging the substance of what the paper proposes. Whether legislative change is achievable is a separate question from whether legislative change is warranted. Many reforms now embedded in California workers' compensation required substantial effort to enact. The 1914 enactment of the Boynton Act was itself the largest such effort, and it succeeded against the opposition of every employer interest at the time. Subsequent reforms have followed the same pattern. The system as currently constituted is the product of legislative action, not the absence of it.

The discipline of this paper is to evaluate current law through the lens of effectiveness rather than under the presumption of correctness. The presumption is not that the law is right and the architecture must fit it. The presumption is that good architecture is right and the law must support it. Where the current law produces outcomes that fail the consideration the bargain promised, the paper recommends changing the law. Where the current law supports the architecture the bargain requires, the paper relies on it.

What this paper offers is not a finished product. It is a starting point for discussion. It defines problems, presents evidence, proposes solutions, and explains why each solution is likely to help. The calibration of specific parameters, thresholds, fees, timelines, and operational details, is the

work of the stakeholder communities responsible for implementing the reforms. The architecture commits. The implementation calibrates.

If counter-arguments are to be made against any reform proposed below, they should be made on the merits of the proposal. The argument that the current law does not permit this is not a counter-argument. It is a description of why the reform is needed. The argument that this is not currently feasible is also not a counter-argument. Feasibility is a straw man. It is premature to assess feasibility before agreement on what needs to change.

The Methodology

Every reform in this paper applies the same methodology. The methodology is not theoretical. It is the methodology that produced the 2017 reform of the QME fee schedule, the most recent successful structural reform inside California workers' compensation.

Five disciplines define the approach.

The first is architecture with levers. The architecture is the structural design, what the reform does, how it operates, what it commits the system to. The levers are the specific parameters that calibrate the architecture: thresholds, fees, timelines, operational details. The architecture should be evaluated on its own merits, not on where the lever is currently positioned. A reform with sound architecture and a badly positioned lever produces suboptimal outcomes that can be corrected. A reform with unsound architecture produces dysfunction that the lever cannot fix.

The second is a problem defined is a problem half solved. Reforms that fail to diagnose precisely produce solutions that miss the structural mechanism actually causing the dysfunction. Each reform in this paper begins with a structural diagnosis. The diagnosis is the gating discipline. If the diagnosis is wrong, the architecture cannot be right.

The third is the majority and minority principle. A minority of actors on every side of the system is responsible for the majority of the dysfunction. Carriers, providers, applicant attorneys, utilization reviewers, employers, defense attorneys, every population has its bad actors and its good ones. The reforms in this paper target the minority bad actors within each stakeholder group through architecture and deliver relief to the majority through the same architecture. No reform targets a side wholesale. Every reform recognizes that the population on each side absorbing the cost of dysfunction is the good-faith majority operating without effective tools to distinguish themselves from the minority.

The fourth is bad actors self-identify. Architecture that aligns incentives with desired outcomes produces a predictable response. The good-actor majority experiences the reform as relief, because the structural distortion they had been absorbing is gone. The bad-actor minority opposes the reform, because the reform makes their behavior either economically irrational or visible. The opposition itself becomes diagnostic information.

The fifth is anything that can be gamed will be gamed. Every architectural element that creates an attack surface will be exploited by the actors most positioned to exploit it. California workers' compensation has demonstrated this principle repeatedly across multiple reform cycles. Each reform proposed below has been evaluated against the question of whether it creates an attack surface. Where surfaces exist, they are removed or structurally protected.

The proof of concept is the QME fee schedule reform of 2017.

The problem was diagnosed precisely. The QME population was shrinking and aging because the existing fee structure made medical-legal evaluation work economically irrational for most physicians. A state audit confirmed this. The complexity tiers in the prior fee schedule created a structural cliff that incentivized upcoding, physicians who needed to be paid adequately for the work they were doing learned to characterize cases as more complex than they were. A subset of physicians went further and were prosecuted. The minority of bad actors gaming the structure was visible in the prosecutions. The majority of QMEs were doing thorough, honest work and absorbing the structural distortion.

The architecture restructured the incentive landscape so that upcoding was no longer possible. The reform replaced the multi-tier complexity cliff with a single complexity factor that could not be gamed, the number of pages in the medical record. The architecture did not target the bad actors. It removed the structural opportunity for the gaming behavior. The lever, the specific fee amounts and the per-page rate, was calibrated to deliver adequate compensation across the population.

A second structural element addressed report-completeness incentives. Supplemental reports addressing information that should have been included in the original report but was not are done without compensation. Supplemental reports addressing information that should have been provided to the QME in advance but was not are done at a cost to the payer. This structure incentivizes thorough work the first time and reduces friction by aligning each party's incentive with the behavior that serves the system.

Once the reform was enacted, the bad actors self-identified through opposition, the good-actor majority welcomed the reform as relief from the structural distortion, and the population began to grow. Younger physicians entered. The backlog of stalled complex cases cleared. More money reached injured workers through faster resolution.

The reform succeeded because every discipline was applied. The diagnosis was precise. The architecture restructured incentives rather than enforcing behavior. The good-actor majority received relief and the bad-actor minority self-identified. The structure resisted gaming because the per-page mechanism made the work auditable.

The reforms proposed in the rest of this paper apply the same methodology. The architecture defines the structural design. The levers are open for stakeholder calibration. The diagnosis precedes every proposal. The discipline of targeting the minority bad actors within each stakeholder group through architecture is preserved. Each reform is evaluated against gaming.

The author proposes what he believes will help, presents the evidence, explains why each architecture is sound, and turns the calibration over to the stakeholder communities responsible for implementation.

Quality

The problem. Treating injured workers is a complicated process. Physicians have clinical training through residency and board certification. Qualified Medical Evaluators have legal training through state certification. The system has constructed an artificial distinction between the two domains even though many of the same substantive issues arise in both the treating and medical-legal environments.

Providers are routinely asked by carriers to address causation, prior injury, permanent and stationary status, and adjustment of modified restrictions. Yet that category of skills is neither taught in residency nor is proficiency in those skills mandated by the state. Treating physicians are not trained in return-to-work guidelines, the procedural infrastructure California workers' compensation requires, the substantive content of the Medical Treatment Utilization Schedule (MTUS), the format and standards of PR-2 and PR-4 reporting, or the Request for Authorization process. The carriers themselves complain about these failures, that RFAs are not filled out properly, that PR-2s are not filled out properly, that physicians keep patients out of work too long with consequent temporary total disability (TTD) costs, and that treating physicians refuse to write PR-4 reports, which necessitates QMEs that would otherwise not be needed. The carriers are right. The patient absorbs the cost of every one of these failures. We owe the patient validation that the providers who treat them are facile in the complexities of treating injured workers.

The proposal, Qualified Medical Treater. Let me pivot a moment to our current QME system.

In order to become a Qualified Medical Evaluator, a physician must study material developed in advance by the state through the Division of Workers' Compensation. The physician must take a test to demonstrate mastery of the material. The physician becomes certified. The physician must complete a certain number of continuing medical education hours per year to maintain certification. The certification allows the physician to conduct qualified medical examinations. The physician is subject to discipline by the state for the quality and timeliness of those reports, and is subject to exclusion from the program for pre-specified infractions, with due process protections.

Now imagine a parallel pathway called a Qualified Medical Treater. In order to treat workers' compensation patients in California, a physician would complete a state-developed curriculum, demonstrate mastery through testing, and maintain certification through continuing medical education. Infractions could be policed by DWC, and bad actors could be removed from the program for pre-specified violations with due process protections. The architecture is not

novel. It is the same architecture the state already runs for evaluators, extended to the physicians who actually treat injured workers.

The QMT body of knowledge addresses the substantive components residency does not cover. MTUS and the application of clinical guidelines. The Request for Authorization process. PR-2 and PR-4 reporting standards. Causation as a clinical question with legal implications. Apportionment doctrine. Permanent and stationary status determinations. Return-to-work guidelines drawing on the AMA published standards and the clinical literature on prolonged absence from work. The infrastructure California workers' compensation actually requires of its treating physicians.

The State Fund precedent demonstrates that this architecture can work in California. Before Concentra was Concentra, when it was U.S. HealthWorks, California State Fund required physicians in its network to complete an online course on return-to-work guidelines as a condition of participation. State Fund did that because it recognized that most physicians treating injured workers had not been trained in return-to-work content. The course was substantive. The mechanism worked. The institutional memory faded as the corporate landscape changed. The precedent remains.

This goes a long way toward solving the problem of quality. The workforce delivering care to injured workers becomes facile not just in clinical discipline but in the nuances of treating injured workers and reporting back to the carrier. The medical board validates clinical competence. The state validates the components the medical board does not validate. The two are complementary, not duplicative.

A specific added benefit of QMT certification illustrates the architectural elegance of the credential. Prior DWC administrative directors have long advocated for an increase to the PR-4 reimbursement, so that the treating physician who already knows the patient well and already knows the chart well can close the case efficiently without needing to send the case to a Qualified Medical Examiner at additional cost and with de novo review of the medical record. Rather than paying the QME fee plus medical record review, a nominal increase to the PR-4 fee would encourage the treating physician to efficiently close the case rather than requiring an otherwise unnecessary QME. The QMT credential makes this structurally possible, because the QMT-certified treating physician has, by virtue of the credential, demonstrated the prerequisite skills to write the PR-4. The patient receives a final determination from the physician who knows their case. The system saves the cost of the unnecessary QME. The treating physician is appropriately compensated for work the physician is now demonstrably qualified to do.

The exemption. Some physicians touch workers' compensation cases incidentally. An endocrinologist managing a patient's diabetes long enough to clear the patient for a work-related surgery. A cardiologist providing pre-operative clearance. An infectious disease specialist consulting on a wound complication. These physicians do not close cases with PR-4 reports. They do not make return-to-work determinations. They do not address causation, apportionment, or permanent and stationary status. Their involvement is incidental to the workplace injury rather

than central to its treatment. Requiring QMT certification of every physician who incidentally encounters a workers' compensation case would be disproportionate to the scope of their involvement.

A volume-based exemption addresses that problem. Physicians who see fewer than a defined number of workers' compensation patients per year, illustratively five or ten, would be exempt from the QMT requirement. The threshold is open to stakeholder calibration. The architectural commitment is narrower and more important: physicians whose practices substantively involve treating workers' compensation injuries should be QMT-certified, while incidental specialty involvement should not trigger a disproportionate credentialing burden.

The pivot, a promise made over five years ago. During the QME fee schedule negotiations more than five years ago, the issue of QME quality was raised by carrier-side stakeholders. At the time, the matter was beyond the scope of the immediate negotiations. The concern was recognized as legitimate by all stakeholders at the table, including by myself. The commitment was made to return to it once the underlying fee schedule reform had taken effect.

The fee schedule reform succeeded. The QME population grew younger and larger. The backlog of stalled cases cleared. More money reached injured workers through faster resolution. Five years on, the deferred commitment is ripe for completion. This document presents the opportunity to return to that promise and fulfill the obligation.

The proposal, QME quality. There is no need to reinvent the wheel. Validation of quality exists in many arenas. The architecture for QME quality has two elements, both educational, neither punitive.

The first is structured peer review of a sample of QME reports against documented quality standards. Specialty societies can perform the audits. Population-level data is published in aggregate. Individual feedback is provided to physicians whose reports show variance from the standard. There are no certification consequences attached to peer review findings. The framework relies on physician professional motivation, physicians are competitive by training and by temperament; a physician told their work shows variance will work to meet the standard.

The second is calibration mechanisms for the application of the AMA Guides Fifth Edition. The calibration is academic and educational, not compliance enforcement. The Almaraz-Guzman doctrine illustrates the discipline. The doctrine was designed as a structural protection, a permitted deviation from the strict AMA Guides rating in narrow circumstances when the strict rating produced an inaccurate result. Practitioner usage has drifted from permitted to use toward required to use. Calibration education addresses this drift through training. QMEs learn to apply Almaraz-Guzman in the narrow scope it was designed for. The doctrine is preserved as the protection it was meant to be rather than becoming a routine mechanism for inflating ratings. This is but one example of an opportunity where getting consistency and predictability across the QME landscape can be accomplished through the quality initiative.

The framework will require funding. Several options exist, and any chosen mechanism should be payment-neutral to the payer, the payer is already paying for the QME report and deserves the quality the report was promised to deliver. One option is a small per-report surcharge deducted from each QME payment, routed to a fund that develops and administers the quality program. The mechanism is structural and operates like a payroll tax, the surcharge applies to every report the QME produces, comes out before the payment reaches the QME, and is invisible to the QME at the per-report level. High-volume QMEs absorb proportionally more in absolute terms, but the per-report rate is uniform across the population. A second option is to increase the ongoing QME annual participation fee to cover the quality program. Either option is payment-neutral to the payer and produces structurally insulated funding for the quality framework.

The author's personal preference is the surcharge approach. QME work is now fairly compensated as evidenced by the influx of new QMEs. If payers are not getting the quality they are paying for, the cost of building the quality assurance should come out of the payment rather than out of new payer assessments. That said, the author humbly defers to the stakeholder community for the determination on the best path forward. The architectural commitment is structurally insulated funding for the quality framework. The specific funding mechanism is a calibration question for stakeholders.

The QMT quality framework will require funding through the same architecture. The most efficient approach is administrative integration with the QME quality framework, one quality assurance infrastructure serving both credentials, with economies of scale that reduce the duplicative cost both frameworks would otherwise incur. Three funding pathways exist. The QME per-report surcharge proposed above can be calibrated upward to cover the QMT quality program as well. The QMT credential itself can carry an annual maintenance fee that includes the quality program funding. The carriers can fund the QMT quality program directly.

The author recommends the first option. The QME per-report mechanism already exists and can be calibrated to cover both programs through a modest adjustment, capturing the economy of scale and requiring no new funding mechanism. There is no longer an access-to-evaluator problem in the system; the QME population is healthy and the credential is functioning. The access problem the document is addressing is on the treating physician side. The latter two funding options compound that problem. Carrier-funded direct support adds new cost to payers who are already paying for the work they are receiving. A QMT maintenance fee or billing surcharge adds cost to the treating physician at precisely the moment the document is asking physicians to participate in workers' compensation, compounding the very disincentive the access reforms are designed to address. The architectural commitment is structurally insulated funding for the integrated quality program. The specific calibration is a stakeholder negotiation.

The architectural elegance. The same quality measures developed for QME can be ported directly into the newly developed QMT process once the QMT credential is in place. One quality assurance architecture serving both credentials. One CME pipeline serving both. One state-

administered system delivering quality on both ends, evaluation and treatment. The economy of scale is real. The patient receives validation that both the physicians treating them and the evaluators opining on their cases are operating against quality assurance the system actually maintains. We trust our credentialed physicians and our credentialed evaluators. We also verify, as Reagan rightly observed any responsible institution must.

The defense of the solutions. QMT is parallel to QME, not novel state imposition. The state already runs the certification architecture. The QME framework works. Extension to treating physicians produces familiarity, captures economy of scale, and avoids parallel state capacity construction.

The QME quality framework operates through education rather than enforcement. There are no certification consequences attached to peer review findings. The structure is robust against gaming because no incentive exists to game peer review when no adverse outcome is at stake. Trust but verify.

QMT is not gatekeeping. The credential is open to any physician who meets the criteria and chooses to maintain it. There is no insider class because there is no inside. The qualification is the credential, and the credential is the qualification.

The patient receives what was promised, care from physicians qualified for the work, and evaluations from evaluators whose work is structurally verified.

Access to Care

The problem. The injured worker does not have adequate access to physicians qualified to treat work-related injuries. Specifically, the injured worker does not have access to specialists. Hand surgeons, orthopedic surgeons, neurologists, physiatrists, spine surgeons, oncologists treating industrially related cancers, the specialists every other Californian with health coverage can reach are systematically unavailable to the injured worker through the normal scheduling pathways available under every other coverage type. The injured worker has access to occupational medicine physicians whose core line of business is treating work injuries. The injured worker does not have, on the same terms as any other patient, access to the specialist depth their injuries require.

There are several predictable counter-arguments. Each one needs to be addressed before the diagnostic can land.

The first is the carrier-side argument that the Medical Provider Network, the MPN, already proves access is adequate. The carrier points to the MPN list and says, look at all the physicians available to your workforce. There are pages of names. The injured worker has plenty of options.

The MPN lists are not accurate. It is widely acknowledged in the practitioner community, and increasingly documented in published industry analysis, that these lists include physicians

who have retired, died, moved, changed addresses, or do not in fact treat workers' compensation patients. Many of the lists are populated by importing PPO contracts wholesale into the workers' compensation context even though the physician never intended to participate as a workers' compensation provider. The list looks robust because the contract count is real. The participation is fictitious. The injured worker discovers that one phone call at a time.

The second counter-argument is that there is a broad access-to-care problem in medicine generally, and that workers' compensation is no different. This is not accurate. The general access-to-care concern is geographic and concentrated in rural and underserved areas. It is not statewide. The workers' compensation access problem is statewide and is specifically a workers' compensation problem. The two issues are distinct. Conflating them protects the dysfunction.

The third counter-argument is that the patient is receiving care, so the access problem is not real. This is technically true and substantively false. Occupational medicine physicians provide front-line access. Specialist access is the structural gap. The injured worker with a complex hand injury, a herniated disc, a torn rotator cuff, a peripheral nerve entrapment, or an industrially related cancer requires a specialist. The fact that the patient can see an occupational medicine physician does not address the specialist gap.

The most direct evidence of the specialist gap is the behavior of California's top medical institutions. UCLA, UCSF, Stanford, Cedars-Sinai, UC Davis, and UC San Diego provide workers' compensation services to their own employees through institutional infrastructure built specifically for that population. They do not provide those services to outside workers' compensation cases. These six institutions are neither villains nor heroes. They are rational economic actors who have determined that the gain-to-pain ratio of workers' compensation is not viable for their business entity. This is not a morality judgment. It is an economic judgment. The injured worker who works for one of these institutions receives the consideration the bargain promised. The injured worker who works for any other California employer does not. The decision the institutions have made is the market's verdict on workers' compensation as currently structured.

The mechanism. The mechanism that produces this verdict is the gain-to-pain ratio. Group health PPO insurance is the most desirable payer in most providers' mix because the gain-to-pain ratio is high. Providers welcome PPO patients into their practices. The economics are rational: the PPO is desirable enough that providers will compete to serve its patients, and the discount they accept is the price of admission to that network.

Workers' compensation sits at the opposite end of the gain-to-pain spectrum. The 150 percent statutory Official Medical Fee Schedule rate is reduced through PPO discounting to approximately 109 percent of Medicare on average per daisyBill, and in some settings substantially lower. The pain side is friction: UR delays, MPN verification chaos, return-to-work negotiation, attorney-mediated communication, and the adversarial posture imported into the clinical encounter. Workers' compensation is therefore an undesirable payer. Specialists who have alternatives self-select out.

The reforms. The access architecture needs to be rebuilt. Three reforms address it.

The first reform replaces the MPN architecture with the QMT credentialing infrastructure stated above which results in a statewide QMT list maintained by DWC as a byproduct of the credentialing process. The intrinsic problem with MPNs is that the architecture lends itself to gamesmanship. We are not accusing any particular carrier of gaming. We are observing that the structural design creates the opportunity. Coventry operates approximately twenty-seven separate MPN products in California. One has to wonder why. Is it because twenty-seven different MPNs are needed to serve genuinely different employer populations or coverage scenarios? Or is it because operating across twenty-seven products creates a level of opacity that no single product needs to be scrutinized for? In the absence of state audits, the carrier or network operator is auditing itself. That is the fox guarding the henhouse. It is not a quality assurance system. It is the absence of one.

DWC has been charged with the Herculean task of auditing MPNs and simply does not have the staffing to do it. This is an unfunded mandate. It is not the most efficient use of workers' compensation dollars or state dollars to maintain twenty-seven Coventry products and dozens of other carrier MPN products with audit obligations the state cannot meet.

The cleaner architecture is the one already proposed above. The QMT credentialing system, parallel to QME, becomes the statewide medical provider network. One list. Maintained by the state. Self-cleaning through the credentialing framework. Visible to everyone. Why would each insurance carrier need to maintain its own MPN when a statewide credentialed list exists? After the reforms above are implemented, every QMT-certified physician is qualified by the state, has demonstrated proficiency in the substantive components of treating injured workers, and is subject to discipline for poor performance. The list mandates quality. The list creates transparency. The patient can go to one place geographically and find every credentialed physician accepting and treating workers' compensation patients in their area.

Before the predictable counter-argument is raised, but you are interfering with competition in the marketplace between carriers, let us be perfectly clear. The workers' compensation system was not created as a profit center for carriers. It was not created as a profit center for providers. It was not created as a profit center for any other stakeholder. It was created as a promise to the injured worker. Everything in workers' compensation must be evaluated through that lens. Access to qualified care is the bargain. Access cannot be subject to competition because access is the consideration the bargain requires.

The second reform is the architectural element that addresses the curated-network capability employers and carriers value. Eliminating MPN does not eliminate the legitimate interest in curated networks. A large employer or self-insured entity may want to designate a small group of physicians it trusts to treat its workforce. A smaller employer paying premiums to a carrier may want the carrier to maintain a curated network on its behalf, accessible across multiple smaller

employers. Both interests are legitimate. Both can be accommodated through a different architectural layer that does not pretend to be access.

The Preferred Provider Network, the PPN, is the architectural answer. The PPN is what the MPN was originally intended to be: a curated network of trusted physicians, voluntarily designated, with the designated physicians earning Utilization Review relief in exchange for the curation. The PPN sits on top of QMT certification. Every PPN-designated physician must be QMT-certified. The PPN curates the QMT population; it does not create a separate population.

A PPN can be designated by an employer directly. A self-insured entity, a large employer with sufficient volume to maintain a curated network, can designate the QMT-certified physicians it wants its workforce to see. A PPN can also be designated by a carrier as a competitive product the carrier offers to its employer clients. A carrier covering many smaller employers, employers individually too small to maintain their own PPN, can designate a curated network across its client portfolio and offer that PPN to its employer clients as part of the coverage relationship. Carriers can compete with each other on the quality of the PPN they offer. One carrier may have a particularly strong orthopedic surgery network. Another may have a particularly strong neurology network. Employers can choose between carriers based on the actual quality of the curated network. This is genuine competition on a legitimate competitive dimension.

The architectural separation matters. Access is provided at the state level through QMT and the DWC list. Access is the floor. It is not subject to negotiation between carriers or between employers. Curation is layered on top. Curation is value-add. Curation can be subject to carrier and employer competition because curation is not access. The decoupling is the principle. Access cannot be a competitive product because access is the bargain. Curation can be a competitive product because curation is service on top of the access guarantee.

The PPN does not restrict patient access. Every QMT-certified physician remains accessible through the standard statewide pathway regardless of whether the patient's employer or carrier has designated a PPN. The PPN is upside for some workers, those whose employer or carrier has designated a quality PPN, and neutral for others. It is never a barrier. The structural pathology of the MPN, restricting patient access through opaque networks while failing to deliver actual access, is not replicated. The PPN designates trust on top of universal qualification rather than restricting access to a subset of an unqualified population.

The PPN compact requires QMT to be in place first. Advancing PPN before QMT would replicate the insider-class pathology the reform is designed to dismantle. PPN before QMT reads as preferred class. PPN after QMT reads as earned trust on top of universal qualification. The sequencing is structural.

Why should UCLA's employees have access to a curated network of trusted physicians and Disney's employees not? The institutional precedent is the proof that the model works. The architecture extends the same capability to every California employer and to the carrier

infrastructure that serves smaller employers, while ensuring that access, the floor, is guaranteed at the state level for every injured worker regardless of employer or carrier.

The third reform addresses the gain side of the gain-to-pain ratio directly. Workers' compensation is unattractive to specialists in part because the realized reimbursement is far below the statutory rate, and the mechanism producing that compression is PPO discounting that has no sound economic foundation in the workers' compensation setting.

An argument can be made to eliminate PPO discounting in workers' compensation entirely. The economic foundation that justifies discounting on the PPO side, the desirable payer environment that produces a buyer's market, does not exist on the workers' compensation side. Without the underlying consideration, the discount is consideration-free. On the underlying logic alone, the cleanest reform is elimination.

A counter-argument can be made that some providers may actually want workers' compensation volume despite the payer-mix dynamic, and that they should be permitted to negotiate discounts in exchange for that volume if they choose to. The more elegant solution is the architecture proposed in AB 1048, transparency of the contract. The discounting party must produce the contract supporting the discount or lose the petition. The mechanism is Independent Bill Review (IBR), California's existing administrative process for resolving bill payment disputes. If the contract is produced, the payment stands. The provider then has the information to make a rational market decision whether they wish to continue providing the discount with that payer. If they do, the relationship continues. If they do not, they terminate the contract. Transparency is the structural answer. It allows providers to opt in or out of the discount based on visible information. AB 1048 was passed unanimously through both California chambers and was held in committee through procedural mechanisms that did not engage the substantive merits.

Either way, leasing a PPO discount into a workers' compensation environment without transparency is exploitation of legal loopholes at the expense of patients.

The painter analogy captures what the current architecture allows. A painter agrees to paint a house for one thousand dollars. The painter completes the work. The owner pays five hundred dollars. The painter asks why. The owner says the painter signed a contract to accept the discount. The painter says no. The owner says yes. The painter says show me the contract. The owner refuses to produce it. The painter says fine, then pay me what we agreed to. The owner says that would be punitive. No court in any other commercial context would entertain this. No layperson would defend it. No reasonable observer would call returning to the agreed-upon price punitive. Yet this is precisely the structure under which PPO discounting in workers' compensation currently operates, and the carrier-side response to AB 1048 has been that paying OMFS, the rate the state established as appropriate compensation, is somehow punitive.

On the predictable response that IBR lacks the institutional capacity to handle these disputes, the discount is a percentage. The contract either supports the percentage or does not. This is third-grade math. IBR is operated by Maximus. The Independent Medical Review system is also operated by Maximus. The same entity the system has chartered to evaluate complex spine surgery authorization requests has the institutional capacity to read a percentage off a contract page. The IBR mechanism uses an existing administrative architecture that has operated without producing floods of frivolous litigation. The filing fee deters frivolous filings. The recovery structure punishes only discounting that cannot be supported by produced contracts. Carriers and TPAs whose discounting practices can be supported by current contracts are unaffected by the reform.

The system is not designed to save carriers money. The system is not designed to make providers rich. The system is designed to uphold the promise to the injured worker. After all, the system is for the injured workers, not for the carriers or the providers.

Utilization Review

The problem. The patient is being denied or delayed in receiving the medical care the bargain promised through an authorization architecture that has drifted away from its design intent at every stage. Initial utilization review applies clinical guidelines so vague that two reviewers reading the same guideline can reach opposite conclusions. The Independent Medical Review system, designed as the appellate check on UR, has collapsed into ratification of the initial denial. The deepest clinical evaluation in the system, the QME report, is statutorily walled off from the question of medical necessity even though no other source of medical opinion in the system has the QME's combination of structural independence and clinical depth. The patient absorbs the cost of every one of these failures.

The vagueness of the underlying clinical authority, and the work that has been done. MTUS is the binding clinical authority for utilization review decisions. The guidelines incorporated into MTUS are written in narrative form. They require interpretive judgment. Two physicians reading the same guideline can reach opposite conclusions about whether a specific treatment meets medical necessity. The vagueness is the structural feature that allows every UR review to depend on which reviewer happens to be assigned, and that allows the bad-actor minority of reviewers to reach denials the architecture cannot challenge because the standard itself is too vague to enforce.

ACOEM, in collaboration with the provider community, has been converting MTUS guideline content into objective decision criteria. The work is not theoretical. Nine upper-extremity diagnoses are complete. Shoulder, knee, hip, and foot/ankle are complete. Spine is approximately 85 percent complete. Pain management is next. Each objective decision criterion is, in operational form, a checklist, bullet-form objective findings with an outlier pathway for cases that present complexity the bulleted criteria do not capture. If the criteria are met, the

treatment meets medical necessity. If the criteria are not met, the denial articulates which specific criterion is unmet and why. The vagueness collapses. The standard becomes auditable on the face of the document.

The work has been done. The state must match our effort.

The first reform is to elevate the objective decision criteria, where they exist, to the operative standard at the top of the existing MTUS hierarchy. UR decisions are made against the criteria. IMR decisions are made against the criteria. The outlier pathway is a substantive review pathway, not a categorical approval mechanism, a reviewer applying the outlier pathway must articulate why the case presents complexity the criteria do not capture. The articulation is auditable. Volume-driven providers cannot game the criteria by checking boxes that produce categorical approvals because the outlier pathway reverts to substantive clinical review whenever the case warrants complexity beyond the bulleted criteria.

This reform does not require new infrastructure. The state's role is to recognize the work that has been done and make it operative through enforcement. Promulgation of the criteria at the payer level for distribution to UR companies. Promulgation at the Maximus level for IMR. Direction from the state to Maximus to use the checklists. Auditing of the appellate process against the checklists. The work has been done. The state must match it through an enforcement mechanism.

The enforcement architecture includes a petition right. When a UR or IMR decision denies an authorization request against met objective decision criteria, the affected provider has standing to petition DWC for enforcement. The applicant attorney representing the injured worker has the same standing. Both halves of the system can activate the enforcement function rather than depending on agency initiative.

The collapse of the appellate function. The Independent Medical Review system was designed as the appellate check on utilization review. The IMR review was supposed to be substantively independent of the prior denial. The reviewer was supposed to evaluate the underlying authorization request against the binding clinical authority, not to evaluate whether the prior denial was reasonable.

The system has not produced this outcome. WCRI, the research arm of the workers' compensation insurance industry, has documented an exceedingly high IMR uphold rate. Treating physicians who interact with the IMR process at scale have observed cases in which the IMR reviewer reproduced the underlying denial's language verbatim, not paraphrased, not restated, reproduced. These cases have been documented and brought to the attention of the DWC medical director and to ACOEM leadership. They are not contested as factual matters.

The system's defenders cite the high uphold rate as evidence that the IMR system is working. The architectural reading is the opposite. IMR is structurally analogous to the appellate division of a court system. Trial courts mostly get it right. When they do not, the appellate body exists to provide substantive independent review. When the appellate body upholds everything, the public

loses confidence in the system because the appellate body has been correctly identified as a rubber stamp on the lower court's decision rather than an independent check on it.

Legal scholarship on the appellate function has long recognized that when the appellate body's decisions concur with the lower-level decision at very high rates, the substantive check the appellate function exists to provide has collapsed. The appellate function becomes, in the language legal scholars have used to characterize the pattern, a rubber stamp on the lower-level decision rather than independent review of it. See Findley, Innocence Protection in the Appellate Process, 93 Marq. L. Rev. 591 (2009); Nash and Pardo, An Empirical Investigation into Appellate Structure and the Perceived Quality of Appellate Review, 61 Vand. L. Rev. 1745 (2008). The structural pattern is the same regardless of the substantive domain in which it appears. An appellate body whose decisions are anchored on the lower-level decision through the input the appellate body receives has lost its substantive character.

If this is the due process expectation we apply to the trial-and-appellate architecture for the citizenry as a whole, that appellate review must be substantive, that high uphold rates indicate appellate failure, that the public's confidence in the appellate system requires independent evaluation, there is no principled basis for denying the same expectation to the vulnerable population that is injured workers. Doctors who experience IMR denials describe the system as rigged. The framing is structural recognition by practitioners of the rubber-stamp pattern legal scholarship has long named. The patient's rights are being confiscated through input architecture they cannot see and would not consent to.

The mechanism is the cognitive anchor. The IMR reviewer is given the prior denial as part of the review packet. Once the prior denial is in front of the reviewer, the cognitive anchor is set. The review becomes a reasonableness check on the existing denial rather than an independent evaluation of the underlying authorization request. This is not malice. It is what humans do when handed a pre-formed conclusion. The structure has produced the predictable outcome. The high concurrence rate WCRI documents is the rubber-stamp pattern legal scholarship recognizes, not evidence the system is working, but evidence the appellate function has collapsed into ratification of the initial review.

The second reform addresses this through input restriction. IMR review is conducted de novo. The reviewer does not receive the prior denial. The review is conducted on the underlying authorization request, the medical record, and the binding clinical authority, including the objective decision criteria established under the first reform. The IMR reviewer's job is not to review the prior decision. The IMR reviewer's job is to review the medical necessity of the underlying authorization request. Where current statute or contract structure frames IMR review as evaluation of the prior denial, the recommendation is to change the framing. The architectural commitment is independent evaluation of medical necessity. The legal pathway to support it is contract amendment between DWC and the IMR contractor, with statutory amendment where required.

The third reform redefines the IMR contractor's chartered function. Currently the contractor's performance is implicitly measured by the uphold rate. The contractor is the entity whose appellate concurrence with the prior denial is being scrutinized. That measurement structure invites the adversarial posture that has produced the rubber-stamp pattern. The contractor's substantive function should be application of the objective decision criteria at the appellate level. The contractor's metric is fidelity to the objective standard. A reviewer who applies the criteria correctly is doing the chartered job, regardless of whether the application produces an uphold or an overturn. A reviewer who fails to apply the criteria correctly is failing at the chartered function, regardless of which direction the failure runs. The contractor publishes the rate at which initial UR decisions failed to apply the objective criteria correctly. That published rate is the structural discipline on initial UR. The contractor is no longer the body whose uphold rate is being scrutinized. The contractor is the body chartered with substantive enforcement of the criteria.

We trust Maximus to do the work in good faith. We do not currently verify that the work meets the standard. Without verification, the imperfections that any institution has accumulate without correction. The patient is the one who absorbs the cost of every uncorrected imperfection. Trust but verify.

The exclusion of the deepest clinical evaluation. The Qualified Medical Evaluator performs medical-legal evaluation after direct examination, patient interview, and comprehensive medical record review. The QME is selected through a panel process designed to produce structural independence, three names per side, each side strikes one, the third is the neutral evaluator. The QME's compensation is governed by the medical-legal evaluation fee schedule and is not tied to authorization outcomes. By every structural measure of independence and clinical depth, the QME is the strongest source of medical opinion in the system on the question of medical necessity.

The current statutory architecture prohibits QMEs from opining on the medical necessity of specific treatment requests. The deepest clinical evaluation is statutorily walled off from the question that most affects the injured worker's care. The system instead relies on UR reviewers operating without examination, often without specialty match, in contractual relationships with the entities requesting review. The contractual relationship that governs UR review is a recognized source of potential conflict of interest, regardless of how individual reviewers conduct their work.

When we preferentially accept the opinion of a doctor who has potential conflict of interest and who reviews only the record without laying hands on the patient over a doctor who has additional state training and certification and actually examines the patient, that simply does not pass the smell test. No layperson would say that choosing the latter over the former comes at the expense of the patient.

The fourth reform makes QME findings on medical necessity admissible as substantive medical evidence. The QME does not authorize treatment. The QME's report becomes part of

the substantive medical evidence the UR or IMR reviewer considers when evaluating whether the treating physician's authorization request meets medical necessity. The reviewer remains the decision-maker. The QME's clinical findings are evidence the decision-maker is required to engage with. Where current statute creates conflict with this architecture, the recommendation is to amend the statute. The architectural commitment is that the deepest clinical evaluation in the system is admissible on the question that most affects the injured worker's care. The legal pathway to support the architecture is statutory amendment.

The structural pairing with the QME quality framework introduced in the Quality section above is the foundation that makes QME admissibility durable. A reform that expanded QME influence on treatment decisions without paired quality assurance would invite the legitimate objection that the QME population's quality variance has been a documented concern. The QME quality framework addresses the variance through educational structures. The objection collapses. The reform lands on prepared ground.

The defense of the solutions. The objective decision criteria reform does not require new infrastructure. ACOEM and the provider community have already done the substantive work. The reform is enforcement of existing work product. The outlier pathway preserves clinical judgment while constraining categorical-approval gaming through the substantive review requirement.

The de novo IMR reform is implementable by contract amendment between DWC and the IMR contractor. It does not require legislation. It operates entirely within the existing IMR contract structure. It changes the input the reviewer sees and lets the rational behavior shift on its own.

The IMR contractor charter reform reframes a relationship that has become adversarial. The contractor is no longer the body whose uphold rate is being scrutinized as evidence of capture. The contractor is the body chartered with substantive enforcement of the objective decision criteria, with a metric the contractor can take pride in performing well. The reform removes the adversarial posture toward the contractor that the current uphold-rate-as-metric structure invites.

QME admissibility is targeted. It does not collapse the medical-legal evaluation function into the treatment authorization function. It does not give the QME direct authorization authority. It does not bypass UR. The reform is admissibility, the QME's clinical findings become evidence the reviewer is required to engage with. The reviewer remains the decision-maker.

The Coalition Structure

Each stakeholder community receives substantive benefits from the integrated package. The reforms are not zero-sum. They restructure dysfunction that has been operating against multiple stakeholders simultaneously.

The injured worker receives faster authorization of settled clinical care, substantive appellate review, specialist access through the QMT credentialing framework and the statewide DWC list, the deepest clinical evaluation in the system informing authorization decisions, a network list that actually represents available physicians, and physicians trained for the substantive demands of treating workers' compensation cases.

The treating physician receives a credential that means something, with a CME pipeline that keeps competence current. Authorization decisions evaluated against an enforceable standard. Bad-actor discounting subject to a self-enforcing remedy. Educational feedback that supports continuous improvement of the work without punitive consequences.

The QME receives a credential whose credibility is being maintained through formalized quality assurance. Calibration that reduces variance. The redemption of a commitment made at the time of the 2017 reform. Educational peer review feedback rather than punitive enforcement.

The carrier receives initial UR decisions reviewed against an enforceable standard. The IMR concurrence problem addressed. The 2017 QME quality concern redeemed. Provider quality assurance through QMT certification, the same quality assurance the carrier community has been asking for.

The employer and self-insured entity receives a network model that actually represents physicians available to employees. The PPN compact as a structural mechanism for designating physicians the employer wants its workforce treated by. UR relief earned through the curation. Reduced friction in return-to-work and authorization that translates into reduced TTD costs.

The applicant attorney receives a credential opining on clients' impairment ratings being subjected to formal quality assurance. Standing to petition DWC enforcement on authorization decisions ignoring objective criteria. The IBR extension as a remedy for the discounting that has reduced what their clients' physicians receive.

The state receives a reform package that operates through structures already running, certification frameworks, public lists, payment routing, contract administration, the bill review and independent medical review mechanisms. Funding mechanisms structurally insulated from annual political reappropriation. Architecture designed to be capture-resistant.

The system as a whole receives a workers' compensation architecture that moves toward the Grand Bargain it was designed to honor.

Enforcement and Sustainability

The reforms are designed with capture-resistance as a structural feature.

Sunshine is the load-bearing enforcement mechanism. Where data exists but is not visible, the reforms make it visible. Where standards exist but are not enforced, the reforms make compliance with the standards visible. The de novo IMR reform combined with the IMR

contractor charter reform produces visible data on the rate at which initial UR decisions correctly applied the objective decision criteria, replacing the uphold-rate metric the prior architecture invited capture against. The IBR extension produces visible data on the rate at which discounting parties cannot produce contracts supporting their discounts. The DWC public list is itself the transparency mechanism. The QME quality framework produces visible aggregate quality data. Published data does the work that enforcement personnel would otherwise have to do.

Funding is structurally insulated from annual political reappropriation. The integrated QME and QMT quality framework is funded through the calibrated per-report surcharge proposed in the Quality section. The IBR mechanism is funded through filing fees. The DWC public list operates as part of the QMT credentialing framework. The funding does not depend on annual political negotiation.

Self-enforcing incentive design substitutes for enforcement infrastructure. A discounting party that applies a discount the party can support with a current contract has no reason to fear the IBR mechanism. A discounting party that applies a discount the party cannot support loses the petition and the filing fee. The reform does not require any actor to be a good actor. The reform makes the rational behavior the compliant behavior.

Petition rights are the backstop where residual enforcement attention is required. The provider whose authorization request was denied against met objective decision criteria has standing to petition DWC. The applicant attorney representing the injured worker has standing to petition. Both halves of the system can activate the enforcement function. Neither half depends on agency initiative.

The reforms operate through structures the state already runs. The reforms add operational scope to working infrastructure rather than building parallel infrastructure. The operational footprint is real and the document does not minimize it. What the reforms do not require is new enforcement personnel or new state capacity demands beyond what the existing infrastructure already provides.

The reforms produce measurable outputs evaluable through operational data the implementing entities collect, with specific metrics calibrated by those entities as the reforms are implemented. The architectural commitment is to evaluability. The specific metrics are operational and calibrated by the stakeholders responsible for implementation.

What This Paper Does Not Address

A reform paper of this scope must be honest about what it does not address. The medical-side reforms, credentialing, quality assurance, authorization, transparency, and access, receive depth here. The indemnity-side architecture is touched only where it intersects with the medical reforms (return-to-work training as part of QMT certification). Several specific dimensions of the system are acknowledged but not addressed in detail: the defense attorney role and structural

incentives that drive defense costs, applicant attorney fee structures, the QME panel selection process, medical lien adjudication, the cumulative trauma claim framework, and total claim cost transparency at the actuarial level. Each has its own structural diagnosis and reform architecture that this paper does not propose to address. They are dimensions where additional work is appropriate.

The reform package this paper proposes is substantial. It is not the totality of what California workers' compensation requires. It is the reform package whose architecture the author is prepared to defend.

Honoring the Bargain

The injured worker who surrendered the right to sue is owed the system that the surrender purchased. The reforms in this paper restore the structural conditions under which the bargain can be honored. They operate through structures the state already runs. They align incentives so that the rational behavior is the compliant behavior. They make transparent what has been opaque. They give every actor in the system a substantively defined role they can perform with integrity.

The Grand Bargain was the moral compact that succeeded the courtroom for injured workers in California more than a hundred years ago. The bargain has not been formally revoked. It has been eroded through the accumulated weight of structural dysfunctions that no individual actor designed but that every actor's rational self-interest has reinforced. The promise was made. The promise must be kept.

We made a promise. We are not keeping it. The reforms above are how we begin to.

The compendium accompanying this submission documents every diagnostic claim, every reform architecture, every implementation pathway, and every capture-resistance feature in full. Any reader who wishes to verify or develop the case for any specific reform will find the documentation in the corresponding part of the compendium as cited throughout this submission.

Appendix: Glossary of Abbreviations

ACOEM, American College of Occupational and Environmental Medicine

AMA, American Medical Association

CHSWC, Commission on Health and Safety and Workers' Compensation

CME, Continuing Medical Education

DWC, Division of Workers' Compensation

IBR, Independent Bill Review

IMR, Independent Medical Review

MPN, Medical Provider Network

MTUS, Medical Treatment Utilization Schedule

OMFS, Official Medical Fee Schedule

PPN, Preferred Provider Network

PPO, Preferred Provider Organization

PR-2, Primary Treating Physician's Progress Report

PR-4, Primary Treating Physician's Permanent and Stationary Report

QME, Qualified Medical Evaluator

QMT, Qualified Medical Treater

RFA, Request for Authorization

TPA, Third-Party Administrator

TTD, Temporary Total Disability

UR, Utilization Review

WCRI, Workers Compensation Research Institute