

State of California
DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

FINAL STATEMENT OF REASONS

Subject Matter:

Workers' Compensation – MEDICAL PROVIDER NETWORK

Title 8, California Code of Regulations, sections 9767.1 through 9768.15

The Administrative Director of the Division of Workers' Compensation, pursuant to the authority granted by Labor Code Sections 59, 133 and 4616, has adopted Article 3.6 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, commencing with Section 9767.1:

Section 9767.1	Medical Provider Networks - Definitions
Section 9767.2	Review of Medical Provider Network Application
Section 9767.3	Application for a Medical Provider Network Plan
Section 9767.4	Cover Page for Medical Provider Network Application
Section 9767.5	Access Standards
Section 9767.6	Treatment and Change of Physicians Within MPN
Section 9767.7	Second and Third Opinions
Section 9767.8	Modification of Medical Provider Network Plan
Section 9767.9	Transfer of Ongoing Care into the MPN
Section 9767.10	Continuity of Care Policy
Section 9767.11	Economic Profiling Policy
Section 9767.12	Employee Notification
Section 9767.13	Denial of Approval of Application and Re-evaluation
Section 9767.14	Suspension or Revocation of Medical Provider Network Plan; Hearing
Section 9767.15	Compliance with Permanent MPN Regulations

UPDATE OF INITIAL STATEMENT OF REASONS AND INFORMATIVE DIGEST

As authorized by Government Code §11346.9(d), the Administrative Director incorporates the Initial Statement of Reasons prepared in this matter. There have been no changes to the statutes directly relating to this rulemaking.

The proposed regulation changes are summarized below.

THE FOLLOWING SECTIONS WERE AMENDED FOLLOWING THE PUBLIC HEARING AND CIRCULATED FOR A 15-DAY COMMENT PERIOD (February 9, 2005 through February 24, 2005.)

Modifications to Section 9767.1 Medical Provider Networks - Definitions

Subdivision (a)(6), the definition of “Employer,” is amended to include “a group self-insurer pursuant to Labor Code section 3700(b) and as defined by Title 8, California Code of Regulations, section 15201(s).” Some self-insured employers are certified as a group of self-insurers by the Office of Self-Insurance Plans. This change will clarify that these self-insured employers may apply to establish a MPN.

Subdivision (a)(18), the definition of “Primary treating physician,” is clarify by the deletion of the words “MPN applicant’s.” This modifying phrase was not only unnecessary but also inaccurate.

Modifications to Section 9767.3 Application for a Medical Provider Network Plan

Subdivision (d)(8)(C) is modified to include the sentence: “The MPN applicant shall confirm that the contractual agreement is in compliance with Labor Code section 4609.” This sentence is added to prevent the MPN networks and MPN applicants from improperly selling, leasing, or transferring health care provider’s contracts.

Subdivision (d)(8)(G) is amended to state: “Describe how the covered employees who are authorized by the employer to temporarily working or travel for work outside of the MPN’s geographical service area will be provided with medical treatment and how injured employees who are no longer employed by the employer and permanently resides outside the MPN geographical service area will be provided with medical treatment.” The changes more closely track the language set forth in section 9767.5 regarding access and require the MPN applicant to specify how medical treatment will be provided to employees temporarily outside the MPN geographical area and to former employees who do not reside within the MPN.

Subdivision (d)(8)(H) is amended to replace the phrase “describe how these services will be made available to the covered employees” with “affirm that referrals will be made to services outside the MPN.” The change is made to clarify that if ancillary services are not within the MPN, then the MPN is required to refer the employee to ancillary services outside the MPN.

Modifications to Section 9767.4 Cover Page for Medical Provider Network Application

Section 4 is amended to include a check-off box if the application is by a group self-insurer as the definition of an employer has been amended to include a group self-insurer.

A typographical error is corrected on line 8.

Section 11 is amended to require the name of the organization for the DWC liaison. This information is necessary in order to properly address correspondence to the DWC liaison.

Modifications to Section 9767.5 Access Standards

Subdivision (e) is amended to state: “(e) The MPN applicant shall have a written policy for arranging or approving medical care ~~if an~~ for: employee (1) employees who are authorized by the employer to temporarily working or traveling for work outside the service area when the need for medical care arises; and (2) employees who are no longer employed by the employer”

and permanently reside outside the MPN geographical service area.” The changes were made to clarify the requirement for the written policy, to include former employees who permanently reside outside the MPN geographical area, and to correct syntax.

Subdivision (g) is amended to state: “(g) For non-emergency services, within one day after the employee files a claim form under Labor Code section 5401, the MPN applicant shall authorize the provision of all treatment as required by Labor Code section 5402. T~~h~~e MPN applicant shall ensure that an appointment for initial treatment is available within 3 business days of the MPN applicant’s receipt of a request for treatment within the MPN.” The added language clarifies that the MPN applicant must authorize the provision of all medical treatment within one day after the employee files a claim form.

Modifications to Section 9767.6 Treatment and Change of Physicians Within MPN

Subdivisions (b) and (d) are amended to replace the work “authorize” with “provide for” for clarification. Some members of the public reported that they understood this section to mean that the treatment should be authorized via the utilization review process as opposed to a requirement to provide medical treatment to the injured worker.

Modifications to Section 9767.7 Second and Third Opinions

Subdivision (a) is amended to replace the words “pursuant to section 9767.6” with “within the MPN.” The change is made to make the subdivision easier to understand.

Subdivisions (b) and (d) are amended to state the “the employee may notify the person designated by the employer or insurer either in writing or orally.” This language is added to clarify that either oral or written notice is acceptable. Subdivisions (b) and (d) are also amended to include the phrase, “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.” This phrase is added so that the employee will be informed of his or her right to request copies of the medical records sent to the second or third physicians by the employer or insurer.

Subdivision (f) is amended to include the sentence: “The employer or insurer shall permit the employee to obtain the recommended treatment within the MPN.” This sentence is added to clarify and ensure that the employer permits the employee to obtain the treatment recommended by the second or third physician within the MPN.

Modifications to Section 9767.8 Modification of Medical Provider Network Plan

Subdivision (e) is amended to include the sentence: “The Administrative Director shall approve or disapprove a plan modification based on the requirements of Labor Code section 4616 et seq. and this article.” This sentence is added to state the standard for the approval or disapproval.

Subdivision (j), the mandatory form, is amended to include a check-off box if the notice is by a group self-insurer as the definition of an employer has been amended to include a group self-insurer.

A typographical error is corrected on line 8.

The form is also amended to require the name of the organization for the DWC liaison. This information is necessary in order to properly address correspondence to the DWC liaison.

Modifications to Section 9767.9 Transfer of Ongoing Care into the MPN

Subdivision (d) is amended to replace the word “that” with “if.” This changes the meaning of the sentence so that the employer or insurer will not need to notify the employee if the physician becomes a MPN provider but the employer or insurer is not requiring the treatment to be within the MPN.

Subdivision (f) is amended to replace the phrase “a language understandable to the employee” with the phrase “English and Spanish and use layperson’s terms to the maximum extent possible.” This change clarifies that the language requirements are the same for this notification as for the other MPN notifications and that the determination regarding the employee’s medical condition be written using layperson’s terms so that the employee will understand the determination.

Modifications to Section 9767.10 Continuity of Care Policy

Subdivision (b), which states, “An acute condition, as referred to in Labor Code section 4616.2, shall have a duration of not more than 30 days,” was added to this section. The subdivision was added to interpret and define the term “a limited duration” as used in Labor Code section 4616.2.

Modifications to Section 9767.12 Employee Notification

Subdivision (a) was amended to delete the words “as required by Labor Code section 4616.3,” because that reference was inaccurate. The words “30 days” were added to state that the initial notification must be sent 30 days prior to the implementation of an approved MPN. This clarifies that the 30 day requirement is consistent with subdivision (c), which requires that employees be notified 30 days prior to a change of the medical network provider.

Subdivision (a)(1) was amended to include the sentence, “The employer or insurer shall provide a toll free telephone number if the MPN geographical service area includes more than one area code.” This requirement will allow employee access to the MPN contact without requiring the employees to bear the cost of a long distance telephone charge.

Subdivision (a)(5) was added. It requires the employer or insurer to inform the employees: “How to access treatment if the employee is authorized by the employer to temporarily work or travel for work outside the MPN’s geographical service area or if the injured employee is no longer employed by the employer and permanently resides outside the MPN geographical service area.” This language matches the access requirement of section 9767.5. The information is necessary to the MPN employees so that they will know what to do if they are injured while temporarily working or traveling for work outside the MPN geographical service area or if they are a former employee who permanently resides outside the MPN geographical service area.

Subdivision (a)(9) was amended to state: “(9) How to obtain a referral to a specialist within the MPN or outside the MPN, if needed.” The added language is necessary because the employee

may need to obtain a specialist outside the MPN is the injury requires a specialist that is not offered within the MPN.

THE FOLLOWING SECTIONS WERE AMENDED FOLLOWING THE FIRST 15 DAY COMMENT PERIOD AND CIRCULATED FOR A SECOND 15-DAY COMMENT PERIOD (May 26, 2005 through June 10, 2005.)

Modifications to Section 9767.1 Medical Provider Networks - Definitions

Subdivision (a)(2): The definition of “Covered employee” is amended to include “or former employee whose employer has ongoing workers’ compensation obligations and...” This phrase is included because this class of employees is entitled to medical care for workers’ compensation injuries.

Subdivision (a)(6): The definition of “Employer” was amended to replace the term “a group self-insurer” with “a group of self-insured employers,” which is the term more commonly used by the public.

In subdivision (a)(20), the definition of “Regional area listing” were added to define the smaller, local list of providers that the MPN applicant may provide to the covered employees pursuant to section 9767.7(b) and (d) and section 9767.12 (a)(3). The definition is necessary to ensure that the employee will be provided with a list of providers including at least the county in which the employee resides or works, or in rural counties, providers within the county in which the employee resides or works and at least two adjacent counties.

The remainder of this section was renumbered.

Modifications to Section 9767.3 Application for a Medical Provider Network Plan

Paragraphs (c)(1), (2), and (3) were added to allow MPN applicants to submit the provider information or ancillary service provider information on computer disks or CD ROMs. Currently the lists are submitted in a printed out form. This modification will save time and paper for the MPN applicants. The modification requires the information to be submitted as a Microsoft Excel sheet or Microsoft Access File so that the Division will be able to read the files. The amendment also requires that the information be set forth in lists which will allow the Division to locate the appropriate information.

Subdivision (d)(8)(A): The word “Describe” was replaced with “State” for clarity purposes.

Subdivision (d)(8)(C): The phrase “in which the providers have agreed to provide treatment for injured workers in the workers’ compensation system” has been added to ensure that the providers included in the MPN will accept workers’ compensation patients. A grammatical change was also made to the last sentence of this subdivision: “The MPN applicant shall confirm that the contractual agreement is in compliance with Labor Code section 4609.” It now states “and that the contractual agreement is in compliance with Labor Code section 4609. “

Subdivision (d)(8)(G) was deleted as redundant because subdivision (d)(8)(H) requires the MPN applicant to describe how the MPN complies with the access standards set forth in 9767.5 for all covered employees. This includes the employees who were previously listed in subdivision

(d)(8)(G).

The following paragraphs in (d) were renumbered.

Subdivision (e)(16) was added to state: “By submission of the application, the MPN applicant is confirming that a contractual agreement in which the providers have agreed to provide treatment for injured workers in the workers’ compensation system exists either between the Health Care Organization and the physicians, providers or medical group practice in the MPN or the MPN applicant and the Health Care Organization and that the contractual agreement with the providers is in compliance with Labor Code section 4609.” This paragraph mirrors the requirement set forth in Subdivision (d)(8)(C) and is added to confirm contracts exist between the parties and to prevent the improper selling, leasing, or transferring of provider’s contracts.

Modifications to Section 9767.4 Cover Page for Medical Provider Network Application

Section 9767.4 was amended to change the check-off box entitled “Group Self-Insurer” to “Group of Self-Insured Employers,” which reflects the change made to the definitions in 9767.1(a)(6).

Modifications to Section 9767.5 Access Standards

Subdivision (e) is amended to clarify that the MPN applicant shall have a written policy for arranging or approving non-emergency medical care for three types of employees who are outside the geographic service area: “(A) a covered employee authorized by the employer to temporarily work or travel for work outside the MPN geographic service area when the need for medical care arises; (B) a former employee whose employer has ongoing workers’ compensation obligations and who permanently resides outside the MPN geographic service area; and (C) an injured employee who decides to temporarily reside outside the MPN geographic service area during recovery.”

Paragraphs (e)(2), (3), and (4) define minimum standards that must be included in the written access policy:

“(e)(2) The written policy shall provide the employees described in subdivision (e)(1) above with the choice of at least three physicians outside the MPN geographic service area who either have been referred by the employee’s primary treating physician within the MPN or have been selected by the MPN applicant. In addition to physicians within the MPN, the employee may change physicians among the referred physicians and may obtain a second and third opinion from the referred physicians.

(3) The referred physicians shall be located within the access standards described in paragraphs (c) and (d) of this section.

(4) Nothing in this section precludes a MPN applicant from having a written policy that allows a covered employee outside the MPN geographic service area to choose his or her own provider for non-emergency medical care.”

Former subdivision (f) has been re-lettered as subdivision (i).

In re-lettered subdivision (f) (formerly subdivision (g)), the phrase “within one day after the employee files a claim form under Labor Code section 5401, the MPN applicant shall authorize the provision of all treatment as required by Labor Code section 5402” has been removed for clarity. This section deals with the requirement of providing an appointment for initial treatment within 3 business days of the request for treatment within the MPN. The reference to Labor Code section 5401 and 5402 was unnecessary in this section and confusing.

Former subdivision (h) has been re-lettered as subdivision (g).

Subdivision (h) has been added to state: “(h) If the primary treating physician refers the covered employee to a type of specialist not included in the MPN, the covered employee may select a specialist from outside the MPN.” As a MPN is only required to have specialists “expected to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged,” it is possible that an employee will be referred to a specialist that is not within the MPN. This subdivision deals with that situation.

Modifications to Section 9767.7 Second and Third Opinions

Subdivisions (b) and (c) are amended by replacing the word “list” with “regional area listing.” “Regional area listing” was added to the definitions in section 9767.1(a)(20). This modification clarifies which providers’ names must be given to the employee when the employee requests a second or third opinion.

Subdivision (f) was modified. The sentence, “The employer or insurer shall permit the employee to obtain the recommended treatment within the MPN,” was deleted from this section and moved to the first sentence in (g).

Subdivision (g) was added and states: “The employer or insurer shall permit the employee to obtain the recommended treatment within the MPN. The covered employee may obtain the recommended treatment by changing physicians to the second opinion physician, third opinion physician, or other MPN physician.” This section clarifies that the employee shall be allowed to obtain the treatment recommended by the second or third opinion and how the treatment may be obtained.

Modifications to Section 9767.8 Modification of Medical Provider Network Plan

Subdivision (a)(1) was amended to include the words “in the composition” to clarify that a Notice of MPN Plan Modification is required if there has been a 10% change in physicians in the MPN, even if the number of physicians remains the same.

Subdivision (a)(4) was added to include a material change in the transfer of care policy.

Subdivision (a)(9) was added to include a material change in any of the employee notification letters required by section 9767.12.

Subdivision (b) was stricken, as subdivision (a) states what must be served, and a copy of the entire application is not required.

In subdivision (e)(2), the word “reconsideration” was replaced with the word “re-evaluation” to distinguish this process from an appeal with the WCAB.

Subdivision (f) was re-written to set forth the re-evaluation procedure. The re-evaluation will be based on documentation. The re-evaluation may be appealed to the WCAB. The section now states:

“(f) Any MPN applicant may request a re-evaluation of the denial by submitting with the Division, within 20 days of the issuance of the Notice of Disapproval, a written request for a re-evaluation with a detailed statement explaining the basis upon which a re-evaluation is requested. The request for re-evaluation shall be accompanied by supportive documentary material relevant to the specific allegations raised and shall be verified under penalty of perjury. The MPN application and modification at issue shall not be re-filed; they shall be made part of the administrative record by incorporation by reference.

(g) The Administrative Director shall, within 45 days of the receipt of the request for a re-evaluation, either:

(1) Issue a Decision and Order affirming or modifying the Notice of Disapproval based on a failure to meet the procedural requirements of this section or based on a failure to meet the requirements of Labor Code section 4616 et seq. and this article; or

(2) Issue a Decision and Order revoking the Notice of Disapproval and issue an approval of the modification;

(h) The Administrative Director may extend the time specified in subdivision (h) within which to act upon the request for a re-evaluation for a period of 30 days and may order a party to submit additional documents or information.

(i) A MPN applicant may appeal the Administrative Director’s decision and order regarding the MPN by filing, within twenty (20) days of the issuance of the decision and order, a petition at the district office of the Workers’ Compensation Appeals Board closest to the MPN applicant’s principal place of business, together with a Declaration of Readiness to Proceed. The petition shall set forth the specific factual and/or legal reason(s) for the appeal. A copy of the petition and of the Declaration of Readiness to Proceed shall be concurrently served on the Administrative Director.”

The section was re-numbered and re-lettered due to the changes made in the subdivisions.

The first page of the form was amended to change the check-off box entitled “Group Self-Insurer” to “Group of Self-Insured Employers,” which reflect the change made to the definitions in 9767.1(a)(6). The second page of the form was amended to add check-off boxes that reflect the requirements to file a Notice of MPN Plan Modification in subdivision (a): “Change in the *composition of Network Providers*,” “Change in transfer of care policy: Provide a copy of the revised written transfer of care policy,” Change in how the MPN complies with the access standards: Explain what change has been made and describe how the MPN still complies with

the access standards,” and “ Change of employee notification letter(s): Provide a copy of the revised notification letter(s).”

The references to the Government Code were deleted as those sections are no longer referenced in the section.

Modifications to Section 9767.9 Transfer of Ongoing Care into the MPN

Subdivision (b) was deleted and replaced with a new (b) which states, “Until the injured covered employee is transferred into the MPN, the employee’s physician may make referrals to providers within or outside the MPN.

Modifications to Section 9767.10 Continuity of Care Policy

Subdivision (c), which states, “‘An extended period of time,’ as referred to in Labor Code section 4616.2(d)(3)(B) with regard to a serious and chronic condition, means a duration of at least ninety days,” was added to this section to interpret and define the term “an extended period of time.

Subdivision (d) was added to the section to require the MPN applicant to include a dispute process in its written continuity of care policy. The requirements are listed and mirror the requirements for the dispute process for transfer of care in section 9767.9.

Modifications to Section 9767.12 Employee Notification

Subdivision (a)(3) was amended to replacing the words “regional list” with “regional area listing.” “Regional area listing” was added to the definitions in section 9767.1(a)(20). This modification clarifies which providers’ names must be given to the employee if the employer chooses to give an initial provider list. The section was also amended to require the employer or insurer to provide the URL address if the provider list is accessible on a website.

Subdivision (a)(4) was amended to require the insurer or employer to state what the access standards are under section 9767.5 to ensure that the covered employees are aware of these requirements.

Subdivision (a)(5) was amended to include the three categories of employees listed in section 9767.5 (e). The subdivision now states: “How to access treatment if (A) the employee is authorized by the employer to temporarily work or travel for work outside the MPN’s geographical service area; (B) a former employee whose employer has ongoing workers’ compensation obligations permanently resides outside the MPN geographical service area; and (C) an injured employee decides to temporarily reside outside the MPN geographic service area during recovery.”

Subdivision (a)(13) was re-worded to state: “A description of the continuity of care policy and a notification that a copy of the policy shall be provided to an employee upon request.” This section was changed to comply with Labor Code section 4616.2(c).

Modification to Section 9767.13 Denial of Approval of Application and Reconsideration

In subdivision (b)(2), the word “reconsideration” was replaced with the words “a re-evaluation” to distinguish this process from an appeal with the WCAB.

Subdivision (c) was re-written to set forth the re-evaluation procedure. The re-evaluation will be based on documentation. The re-evaluation may be appealed to the WCAB. The section now states:

“(c) Any MPN applicant may request a re-evaluation by submitting with the Division, within 20 days of the issuance of the Notice of Disapproval, a written request for a re-evaluation with a detailed statement explaining the basis upon which a re-evaluation is requested. The request for a re-evaluation shall be accompanied by supportive documentary material relevant to the specific allegations raised and shall be verified under penalty of perjury. The MPN application at issue shall not be re-filed; it shall be made part of the administrative record by incorporation by reference.

(d) The Administrative Director shall, within 45 days of the receipt of the request for a re-evaluation, either:

(1) Issue a Decision and Order affirming or modifying the Notice of Disapproval based on a failure to meet the procedural requirements of this section or based on a failure to meet the requirements of Labor Code section 4616 et seq. and this article; or

(2) Issue a Decision and Order revoking the Notice of Disapproval and issue an approval of the MPN.

(e) The Administrative Director may extend the time specified in subdivision (d) within which to act upon the request for a re-evaluation for a period of 30 days and may order a party to submit additional documents or information.

(f) A MPN applicant may appeal the Administrative Director’s decision and order regarding the MPN by filing, within twenty (20) days of the issuance of the decision and order, a petition at the district office of the Workers’ Compensation Appeals Board closest to the MPN applicant’s principal place of business, together with a Declaration of Readiness to Proceed. The petition shall set forth the specific factual and/or legal reason(s) for the appeal. A copy of the petition and of the Declaration of Readiness to Proceed shall be concurrently served on the Administrative Director.”

The references to the Government Code were deleted those sections are no longer referenced in the section.

Modifications to Section 9767.14 Suspension or Revocation of Medical Provider Network Plan; Hearing

Subdivisions (b) through (f) have been amended to provide for a re-evaluation process and subsequent appeal from the Administrative Director’s suspension or revocation of approval of a MPN plan. The sections now state:

“(b) If one of the circumstances in subdivision (a) exists, the Administrative Director shall notify the MPN applicant in writing of the specific deficiencies alleged. The Administrative Director shall allow the MPN applicant an opportunity to correct the deficiency and/or to respond within ten days. If the Administrative Director determines that the deficiencies have not been cured, he or she shall issue a Notice of Action to the MPN applicant that specifies the time period in which the suspension or revocation will take effect and shall transmit the Notice of Action to the MPN applicant by U.S. Mail.

(c) A MPN applicant may request a re-evaluation of the suspension or revocation by submitting to the Administrative Director, within 20 days of the issuance of the Notice of Action, a written notice of the request for a re-evaluation with a detailed statement explaining the basis upon which a re-evaluation is requested. The request for a re-evaluation shall be accompanied by supportive documentary material relevant to the specific allegations raised and shall be verified under penalty of perjury. The MPN application at issue shall not be re-filed; it shall be made part of the administrative record and incorporated by reference.

(d) The Administrative Director shall, within 45 days of the receipt of the request for a re-evaluation, either:

(1) Issue a Decision and Order affirming or modifying the Notice of Action based on a failure to meet the procedural requirements of this section or based on a failure to meet the requirements of Labor Code section 4616 et seq. and this article;

(2) Issue a Decision and Order revoking the Notice of Action;

(e) The Administrative Director may extend the time specified in subdivision (d) within which to act upon the request for a re-evaluation for a period of 30 days and may order a party to submit additional documents or information.

(f) A MPN applicant may appeal the Administrative Director’s decision and order regarding the MPN by filing, within twenty (20) days of the issuance of the decision and order, a petition at the district office of the Workers’ Compensation Appeals Board closest to the MPN applicant’s principal place of business, together with a Declaration of Readiness to Proceed. The petition shall set forth the specific factual and/or legal reason(s) for the appeal. A copy of the petition and of the Declaration of Readiness to Proceed shall be concurrently served on the Administrative Director.”

THE FOLLOWING SECTIONS WERE AMENDED FOLLOWING THE SECOND 15 DAY COMMENT PERIOD AND CIRCULATED FOR A THIRD 15-DAY COMMENT PERIOD (June 28, 2005 through July 13, 2005.)

Modifications to Section 9767.1 Medical Provider Networks - Definitions

Subdivision (a)(6): The definition of “Employer” was amended to include the term “the Self-Insurer’s Security Fund.” Labor Code section 3743(c) provides that the Fund shall have the same rights as an insolvent self-insurer (self-insured employer) to investigate, adjust and pay claims. Therefore, the Fund is an employer within the meaning of Labor Code section 4616(a)(1) and section 4616.5.

Subdivision (a)(10): The definition of “Insurer” was amended to include the term “California Insurance Guarantee Association.” In *CIGA v. DWC* (April 26, 1005), the WCAB held that although CIGA was not an “ordinary” insurer, since Labor Code section 1063.1 provides that CIGA shall have the same rights as an insolvent insurer to investigate, adjust and pay claims, “CIGA is an ‘insurer’ within the meaning of Labor Code section 4616(a)(1) and is entitled to submit a MPN application.”

In subdivision (a)(20), the definition of “Regional area listing” was amended. The definition now states:

- (20) “Regional area listing” means either:
- A) a listing of all MPN providers within a 15-mile radius of an employee’s worksite and/or residence; or
 - B) a listing of all MPN providers in the county where the employee resides and/or works if
 1. the employer or insurer cannot produce a provider listing based on a mile radius
 2. or by choice of the employer or insurer, or upon request of the employee.
 - C) If the listing described in either (A) or (B) does not provide a minimum of three physicians of each specialty, then the listing shall be expanded by adjacent counties or by 5-mile increments until the minimum number of physicians per specialty are met.

The definition was amended in response to comments recommending including a mile radius listing because for urban counties such as Los Angeles, a list of all providers would be huge, whereas a mile radius will allow for a more reasonable list of providers.

References to the Labor Code sections 1063.1, 3700, and 3743, regarding the Self-Insurer’s Security Fund and CIGA, and reference to *CIGA v. DWC* (April 26, 1005) have been added.

Modifications to Section 9767.3 Application for a Medical Provider Network Plan

Subdivision (d)(8)(C): The last sentence of this subdivision has been modified to state: “By submission of the application, the MPN applicant is confirming that a contractual agreement exists with the physicians, providers or medical group practice in the MPN to provide treatment for injured workers in the workers’ compensation system and that the contractual agreement is in compliance with Labor Code section 4609, if applicable.”

The subdivision was re-worded in response to comments.

Subdivision (e)(16)(G): The subdivision has been modified to state: “By submission of the application, the MPN applicant is confirming that a contractual agreement exists with the physicians, providers or medical group practice in the MPN to provide treatment for injured workers in the workers’ compensation system and that the contractual agreement is in compliance with Labor Code section 4609, if applicable.” This paragraph mirrors the requirement set forth in subdivision (d)(8)(C).

The subdivision was re-worded in response to comments.

The reference to Labor Code section 4609 was also added.

Modifications to Section 9767.4 Cover Page for Medical Provider Network Application

Section 9767.4 was amended to include a check-off box entitled “Self-Insurer Security Fund,” which reflects the change made to the definitions in section 9767.1(a)(6).

The references to Labor Code sections 3700 and 3743 were also added.

Modifications to Section 9767.8 Modification of Medical Provider Network Plan

Subdivision (a)(1) was amended to delete the words “in the composition” and to add the words “number or specialty of.” The phrase “since the approval date of the previous MPN Plan application or modification” was also added so that the sentence now reads: “A change of 10% or more in the number or specialty of providers participating in the network since the approval date of the previous MPN Plan application or modification.”

The change was made in response to comments and to clarify that a Notice of MPN Plan Modification is required if there has been a 10% change in number or specialty of providers in the MPN, even if the number of physicians remains the same. This is necessary to ensure the access standards are still met.

Subdivision (a)(2) was modified by the addition of the phrase “since the approval date of the previous MPN Plan application or modification” for clarification.

Subdivisions (a)(3), (4) and (9) the word “material” was changed to “substantive” for clarity. Also in subdivision (a)(9), the word “letters” was changed to “materials” because materials is a more description term of the documents that are sent to the employees.

The first page of the form was amended to add a check-off box entitled “Self-Insurer Security Fund,” which reflects the change made to the definitions in 9767.1(a)(6). The second page of the form was amended to reflect the changes made in subdivision (a): “Change of 10% or more in the number or specialty of Network Providers since the approval date of the previous MPN Plan application or modification,” “Change of 25% or more in the number of covered employees since the approval date of the previous MPN Plan application or modification,” and “Change of employee notification materials: Provide a copy of the revised notification materials.”

The references to Labor Code section 3700, 3743, and 4616.5 were added.

Modifications to Section 9767.9 Transfer of Ongoing Care into the MPN

Subdivision (e)(1) was amended to change the definition of “acute” from “not more than 30 days” to “less than three months” in response to comments and to be consistent with ACOEM: “The International Association for the Study of Pain has stated that three months in the definitive time frame...” (page 108). This definition is also the same as the one stated in proposed section 9792.20, Medical Treatment Utilization Schedule regulations.

The first sentence of subdivision (f) was re-worded for clarity and syntax. It now states: “If the employer or insurer decides to transfer the covered employee’s medical care to the medical provider network, the employer or insurer shall notify the covered employee of the determination regarding the completion of treatment and the decision to transfer medical care into the medical provider network.”

The following sentence was added to subdivision (g): “The treating physician shall provide the report to the covered employee within twenty calendar days of the request. If the treating physician fails to issue the report, then the determination made by the employer or insurer referred to in (f) shall apply.” This sentence was added to provide a time frame for the treating physician to provide the medical report and to provide a remedy if the treating physician does not issue a report.

Modifications to Section 9767.10 Continuity of Care Policy

Subdivision (b) was amended to change the definition of “acute” from “not more than 30 days” to “less than three months” in response to comments and to be consistent with ACOEM: “The International Association for the Study of Pain has stated that three months in the definitive time frame...” (page 108). This definition is also the same as the one stated in proposed section 9792.20, Medical Treatment Utilization Schedule regulations.

The following sentence was added to subdivision (d)(2): “The treating physician shall provide the report to the covered employee within twenty calendar days of the request. If the treating physician fails to issue the report, then the determination made by the employer or insurer referred to in (d)(1) shall apply.” This sentence was added to provide a time frame for the treating physician to provide the medical report and to provide a remedy if the treating physician does not issue a report.

Modifications to Section 9767.12 Employee Notification

Subdivision (a)(12) was amended to add the words “and a notification that a copy of the policy shall be provided to an employee upon request.” This phrase was added so that the transfer of care policy must be provided if requested.

Modification to Section 9767.13 Denial of Approval of Application and Re-evaluation

The title of this section was corrected by replacing the word “reconsideration” with the word “Re-evaluation” to be consistent with the remainder of the section.

New Proposed Section 9767.15 Compliance with Permanent MPN Regulations

This section has been added in response to comments, to clarify the status of MPNs established under the emergency regulations, and to set forth that MPNs that were established under the

emergency regulations are not required to submit Notices of MPN Plan Modifications and comply with the permanent regulations, unless the MPN is making a change listed in section 9767.8. The section provides:

- a. This section applies to MPNs that were approved by the Administrative Director pursuant to the emergency Medical Provider Network regulations effective November 1, 2004
- b. Employers or insurers whose MPNs were approved pursuant to the emergency Medical Provider Network regulations are not required to submit a Notice of MPN Plan Modification to comply with the new or revised sections of the permanent regulations, including:
 1. Section 9767.3(d)(8)(C) or Section 9767.3(d)(16) regarding the contractual agreements contained in the Application for a Medical Provider Network Plan provisions.
 2. Sections 9767.5(e)(1), (e)(2), (e)(3), (e)(4), 9767.5(h) and 9767.5(i) of the Access Standards provisions.
 3. Section 9767.9(g) provision providing a timeline for the treating physician's report and what happens if the treating physician fails to issue a timely report contained in the Transfer of Ongoing Care into the MPN provisions.
 4. Section 9767.10(b)(c) and (d) of the Continuity of Care provisions.
 5. Section 9767.12 (a), (a)(1), (a)(2), (a)(3), (a)(4) and (a)(5) of the Employee Notification provisions.
- c. At the time an employer or insurer with an approved MPN pursuant to the emergency Medical Provider Network regulations submits a Notice of MPN Plan Modification, the employer or insurer shall be required to verify compliance with the sections of the MPN permanent regulations listed in subdivision (b) above.

THE FOLLOWING NON-SUBSTANTIVE / CORRECTIONS WITHOUT REGULATORY EFFECT WERE MADE TO THE TEXT OF THE REGULATIONS AFTER THE CLOSE OF THE FINAL COMMENT PERIOD

UPDATE OF MATERIAL RELIED UPON / DOCUMENTS ADDED TO RULEMAKING FILE

In addition to the documents identified in the Initial Statement of Reasons the following documents were relied upon by the Division and were made available to the public as required by Government Code Section 11347.1.

Title of Document Added to Rulemaking File Dates of Availability for Public Comment

Comments received by the Division of Workers' Compensation concerning the Division's proposed changes.	January 28, 2005 through March 16, 2005 March 30, 2005 through April 14, 2005.
Pre-Notice comments from DWC Forum	October 27, 2005 through November 5, 2004 November 24, 2004 through December 3, 2004

LOCAL MANDATES DETERMINATION

- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district. The proposed amendments do not apply to any local agency or school district.
- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None. The proposed amendments do not apply to any local agency or school district.
- Other nondiscretionary costs/savings imposed upon local agencies: None. The proposed amendments do not apply to any local agency or school district.

CONSIDERATION OF ALTERNATIVES

The Division considered all comments submitted during the public comment periods, and made modifications based on those comments to the regulations as initially proposed. The Administrative Director has now determined that no alternatives proposed by the regulated public or otherwise considered by the Division of Workers' Compensation would be more effective in carrying out the purpose for which these regulations were proposed, nor would they be as effective and less burdensome to affected private persons and businesses than the regulations that were adopted.

SUMMARY OF COMMENTS RECEIVED AND RESPONSES THERETO CONCERNING THE REGULATIONS ADOPTED

The comments of each organization or individual are addressed in the following charts.

The public comment period was as follows:

Initial 45-day comment period on proposed regulations:

December 15, 2004 through February 2, 2005.

First 15-day comment period on modifications to proposed text:

February 9, 2005 through February 24, 2005.

Second 15-day comment period on modifications to proposed text:

May 26, 2005 through June 10, 2005.

Third 15-day comment period on modifications to proposed text:

June 28, 2005 through July 13, 2005.