

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION
455 Golden Gate Avenue, 9th Floor
San Francisco, CA 94102

NOTICE OF EMERGENCY REGULATORY ADOPTION

Finding of Emergency and Informative Digest

Subject Matter of Regulations: Workers' Compensation – Medical Provider Networks

The Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her by Labor Code sections 59, 133, and 4616, proposes to adopt Article 3.5 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, commencing with Section 9767.1. This action is necessary in order to implement, on an emergency basis, the provisions of Labor Code sections 4616 through 4616.7, as implemented by Senate Bill 899 (Chapter 34, stats. of 2004, effective April 19, 2004). The regulations are mandated by Labor Code section 4616(g), which provides that on or before November 1, 2004 the Administrative Director "shall adopt regulations implementing this article."

Finding of Emergency

The Administrative Director of the Division of Workers' Compensation finds that the proposed regulations attached hereto are necessary for the immediate preservation of the public peace, health and safety or general welfare.

Statement of Emergency

The containment of medical costs in the workers' compensation system is critical for the future of California. The total annual costs of the California workers' compensation system more than doubled from 1995 to 2002, growing from about \$9.5 billion to about \$25 billion. During the same time, workers' compensation medical expenditures increased from \$2.6 billion to \$5.3 billion per year. It is estimated that in 2004, medical payments will account for two-thirds of all workers' compensation costs. (Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Care in California: Costs, Fact Sheet Number 2, August 2003, http://www.dir.ca.gov/chswc/WC_factSheets/WorkersCompFSCost.pdf.)

The rise in medical care expenditures has adversely affected the entire workers' compensation system. Employers in California experience higher costs for workers' compensation medical care than employers in most other states. California ranks highest in workers' compensation premiums. Studies indicate that the high utilization of specific kinds of medical services in California workers' compensation system is one of the major reasons for the difference. Pursuant to the Workers' Compensation Research Institute, the median number of medical visits per workers' compensation claim in California is more than 70 percent greater than other states. The higher utilization is mostly due to higher rates of specific kinds of services including, physical

medicine, psychological therapy, and chiropractic care. Further, the evidence for higher medical costs in workers' compensation relative to group health is consistently strong. Studies indicate a substantial positive differential for workers' compensation medical care. The studies find that workers' compensation pays 33%-300% more than group health to treat the same conditions. (Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Care in California: Costs, Fact Sheet Number 2, August 2003, http://www.dir.ca.gov/chswc/WC_factSheets/WorkersCompFSCost.pdf; Outline: Estimating the Range of Savings from Introduction of Guidelines Including ACOEM (Revised), Frank Neuhauser, UC DATA/Survey Research Center, University of California, Berkeley, October 20, 2003, <http://www.dir.ca.gov/chswc/EstimatingRangeSavingsGuidelinesACOEM.doc>.)

In response to the State's widely-acknowledged workers' compensation crisis, the Legislature passed Senate Bill 899 (Chapter 34, stats. of 2004, effective April 19, 2004). Senate Bill 899 included several provisions designated to control workers' compensation costs including Labor Code section 4616 et seq. which provides for the implementation of medical provider networks.

Labor Code section 4616 provides that an employer (defined by Labor Code section 4616.5 as a self-insured employer, joint powers authority, or the state) or an insurer may establish or modify a medical provider network for the provisions of medical treatment to injured employees. The medical treatment must be readily available at reasonable times to all employees and all medical treatment must be readily accessible. If the employer or insurer has established a medical provider network and the employee has not predesignated a physician pursuant to Labor Code section 4600(d), the injured employee will be required to seek his or her medical treatment from a physician within the medical provider network.

Labor Code section 4616 et seq. is not self-executing. Labor Code section 4616 provides that on or before November 1, 2004, the Administrative Director, in consultation with the Department of Managed Health Care, shall adopt regulations implementing the article and develop regulations that establish procedures for purposes of making medical provider network modifications. The statute further provides that the Administrative Director shall approve of the medical provider network plan if she determines that the plan meets with the statute's requirements. If the Administrative Director does not act on the plan within 60 days of submitting the plan, it shall be deemed approved. Labor Code section 4616(a) provides that an insurer or employer may establish or modify a medical network on or after January 1, 2005. Therefore, it is essential that these regulations be effective on or before November 1, 2004 to allow the Administrative Director 60 days to approve submitted plans and to allow the medical network plans to be established by January 1, 2005.

This mandatory program, which is intended to generate substantial savings, will not be effective without regulatory interpretation. Further, lack of guidance and defined structure for medical provide networks will result in confusion over the legal requirements, likely resulting in increased litigation and costs. The regulations define the terms used in the controlling statutes, clarify the application process, clarify the medical provider network requirements, define the access standards, set forth the employee notification requirements, clarify the procedures regarding the change of a physician within the medical provider network, set forth the procedures for obtaining a second and third opinion, define the procedure for modifying an

approved medical provider network plan, set forth the procedure for transfers of on-going care into a medical provider network, provide the reconsideration procedure for a medical provider network applicant if the submitted plan is denied, and provide a procedure for the suspension or revocation of an approved medical provider network plan. Labor Code section 4616 requires the Administrative Director to adopt regulations that implement medical providers networks. By doing so, insurers and employers will be able to establish medical provider networks that will reduce medical costs but provide quality medical care to injured employees.

The Administrative Director has therefore determined that the emergency adoption of the proposed regulations is necessary for the immediate preservation of the public peace, health and safety or general welfare.

Authority and Reference

The Administrative Director is undertaking this regulatory action pursuant to the authority vested in her by Labor Code sections 59, 133, and 4616.

Reference is to Labor Code sections 3208, 3209.3, 3209.5, 3702, 4062, 4604.5, 4616, 4616.1, 4616.2, 4616.3, 4616.4, 4616.5, 4616.7, 5300, 5307.27, 5401; Government Code sections 11445.10 through 11445.60.

Informative Digest

These regulations are required by a legislative enactment - Senate Bill 899 (Chapter 34, stats. of 2004, effective April 19, 2004). Senate Bill 899 included Labor Code sections 4616 through 4616.7, which provide for the establishment of medical provider networks.

Labor Code section 4616 provides that on or after January 1, 2005, an insurer or employer may establish or modify a medical provider network for the provision of medical treatment to injured employees. The network must include physicians primarily engaged in the treatment of occupational injuries and physicians primarily engaged in the treatment of nonoccupational injuries. The goal is that at least 25 percent of the medical provider network's physicians be primarily engaged in the treatment of nonoccupational injuries. This section also requires that the number of physicians in the medical provider network be sufficient to enable treatment for injuries or conditions to be provided in a timely manner and include an adequate number and type of physicians, as described in Section 3209.3, or other providers, as described in Section 3209.5, to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged, and the geographic area where the employees are employed. Medical treatment for injuries must be readily available at reasonable times to all employees. To the extent feasible, all medical treatment for injuries shall be readily accessible to all employees. With respect to availability and accessibility of treatment, the Administrative Director is required to consider the needs of rural areas, specifically those in which health facilities are located at least 30 miles apart.

Labor Code section 4616 (b) provides that the employer or insurer shall submit a plan for the medical provider network to the Administrative Director for approval. The Administrative

Director shall approve the plan if he or she determines that the plan meets the requirements of this section. If the Administrative Director does not act on the plan within 60 days of submitting the plan, it shall be deemed approved.

Labor Code section 4616 also provides that physician compensation may not be structured in order to achieve the goal of reducing, delaying, or denying medical treatment or restricting access to medical treatment. Additionally, all treatment provided shall be provided in accordance with the medical treatment utilization schedule established pursuant to Section 5307.27 or the American College of Occupational Medicine's and Environmental Occupational Medicine Practice Guidelines, as appropriate.

Labor Code section 4616 (g) provides that on or before November 1, 2004, the Administrative Director, in consultation with the Department of Managed Health Care, shall adopt regulations implementing this article. The Administrative Director shall develop regulations that establish procedures for purposes of making medical provider network modifications.

Labor Code section 4616.1 requires an insurer or employer that uses “economic profiling” to file a description of the policy with the Administrative Director and provide a copy to the physician or provider.

Labor Code section 4616.2 requires an employer or insurer to file a continuity of care policy with the Administrative Director and sets forth the requirements for completion of treatment with a terminated provider.

Labor Code section 4616.3 provides that when the injured employee notifies the employer of the injury or files a claim for workers’ compensation with the employer, the employer shall arrange an initial medical evaluation and begin treatment. The employer shall notify the employee of his or her right to be treated by a physician of his or her choice after the first visit from within the medical provider network, and the method by which the list of participating providers may be accessed by the employee. This section also provides that if an injured employee disputes either the diagnosis or the treatment prescribed by the treating physician, the employee may seek the opinion of another physician in the medical provider network. If the injured employee disputes the diagnosis or treatment prescribed by the second physician, the employee may seek the opinion of a third physician in the medical provider network.

Labor Code section 4616.4 allows the Administrative Director to contract with individual physicians to act as independent medical reviewers. If, after the third physician’s opinion, the treatment or diagnostic service remains disputed, the injured employee may request an independent medical review.

Labor Code section 4616.5 defines “employer” as “a self-insured employer, joint powers authority, or the state.”

Labor Code section 4616.6 provides that no additional examinations shall be ordered by the appeals board and no other reports shall be admissible to resolve any medical network provider controversy.

Labor Code section 4616.7 provides that a health care organization that is certified under Labor Code section 4600.5 shall be deemed approved if 25% of the physicians are primarily engaged in nonoccupational medicine and all other requirements of the article are met. A health care service plan, group disability insurance policy, and any Taft-Hartley health and welfare fund shall be deemed approved if it has a reasonable number of physicians with competency in occupational medicine, as determined by the Administrative Director.

Pursuant to the requirement of Labor Code section 4616(g), the Administrative Director has consulted with the Department of Managed Health Care regarding these proposed regulations.

The Administrative Director now adopts administrative regulations governing medical provider networks. These regulations implement, interpret, and make specific sections 4616 through 4616.7 of the Labor Code as follows:

1. Section 9767.1 Medical Provider Networks – Definitions.

This section provides definitions for the following key terms: “Ancillary services,” “Covered employee,” “Division,” “Economic profiling,” “Emergency health care services,” “Employer,” “Group Disability Insurance Policy,” “Health Care Organization,” “Health Care Service Plan,” “Insurer,” “Medical Provider Network,” “Medical Provider Network Plan,” “MPN Applicant,” “Nonoccupational Medicine,” “Occupational Medicine,” “Physician primarily engaged in treatment of nonoccupational injuries,” “Primary care physician,” “Primary treating physician,” “Provider,” “Residence,” “Second Opinion,” “Taft-Hartley health and welfare fund,” “Third Opinion,” “Treating physician,” and “Workplace.” The definitions are provided to ensure that their meaning, as used in the regulations, will be clear to the regulated public.

2. Section 9767.2 Review of Medical Provider Network Application

This section provides that the Administrative Director shall approve or disapprove the medical provider network (“MPN”) application within 60 days of receipt of a complete application or the application shall be deemed approved. An approval number shall be assigned to the MPN plan. The section also provides that the Administrative Director shall provide notification to the MPN applicant setting forth the date the application was received and informing the MPN applicant if the application is not complete and the item(s) necessary to complete the application.

3. Section 9767.3 Application for a Medical Provider Network Plan

This section sets forth what information is required from the MPN applicant on the MPN application. There is a subdivision setting forth the requirements for a network that is not a Health Care Organization, Health Care Service Plan, Group Disability Insurance Policy, or Taft-Hartley Health and Welfare Fund; a subdivision setting forth the requirements for a network that is a Health Care Organization; and a subdivision setting forth the requirements for a network that is a Health Care Service Plan, Group Disability Insurance Policy, or Taft-Hartley Health and Welfare Fund. The MPN applicant may submit for approval one or more medical provider networks in its application and shall submit one original and one copy of the Cover Page for

Medical Provider Network Application and one original and one copy of the application to the Division of Workers' Compensation.

4. Section 9767.4 Cover Page for Medical Provider Network Application

This section is the mandatory form entitled "Cover Page for Medical Provider Network Application." This form, which requests information about the MPN applicant, the medical provider network, the liaison to the DWC, and an authorized signature, must be completed and submitted with the Medical Provider Network application to the Division of Workers' Compensation.

5. Section 9767.5 Access Standards

This section provides for access standards. An MPN must have a primary care physician and a hospital for emergency health care services, or if separate from such hospital, a provider of all emergency health care services, within 30 minutes or 15 miles of each covered employee's residence or workplace. In addition, an MPN must have providers of occupational health services and specialists within 60 minutes or 30 miles of a covered employee's residence or workplace.

However, if a MPN applicant believes that, given the facts and circumstances with regard to a portion of its service area, specifically rural areas including those in which health facilities are located at least 30 miles apart, the accessibility standards are unreasonably restrictive, the MPN applicant may propose alternative standards of accessibility for that portion of its service area. The MPN applicant shall do so by including the proposed alternative standards in writing in its original plan application or in a notice of MPN plan modification. The alternative standards shall provide that all services shall be available and accessible at reasonable times to all covered employees.

This section also provides that the MPN applicant shall have a written policy for arranging or approving medical care if an employee is temporarily working or traveling for work outside of the service area when the need for medical care arises and a written policy to allow an injured employee to receive emergency medical treatment from a medical service or hospital provider who is not a member of the MPN.

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

6. Section 9767.6 Treatment and Change of Physicians Within MPN

This section provides that when the injured covered employee notifies the employer of the injury or files a claim for workers' compensation with the employer, the applicant shall arrange an

initial medical evaluation with a MPN physician. Within one working day after an employee files a claim form under Labor Code section 5401, the employer or insurer shall authorize the provision of all treatment, consistent with guidelines adopted by the Administrative Director pursuant to Labor Code section 5307.27 or, prior to the adoption of these guidelines, the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM), and for all injuries not covered by the ACOEM guidelines or guidelines adopted by the Administrative Director, authorized treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based. The employer or insurer shall authorize the treatment with MPN providers for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is rejected. Until the date the claim is rejected, liability for the claim shall be limited to ten thousand dollars (\$10,000).

This section also provides that at any point in time after the initial medical evaluation with a MPN physician, the covered employee may select a physician of his or her choice from within the MPN. The insurer or employer shall notify the employee of his or her right to be treated by a physician of his or her choice within the MPN after the first visit with the MPN physician and the method by which the list of participating providers may be accessed by the employee.

7. Section 9767.7 Second and Third Opinions

This section sets forth the process for obtaining second and third physician opinions if the covered employee disputes either the diagnosis or the treatment prescribed by the treating physician. During this process, the employee is required to continue his/her treatment with the treating physician or a physician of his or her choice within the MPN pursuant to section 9767.6.

This section also provides that the second and third opinion physicians shall render his or her opinion of the disputed diagnosis or treatment in writing and offer alternative diagnosis or treatment recommendations, if applicable. Any recommended treatment shall be in accordance with Labor Code section 4616(e). The second and third opinion physicians may order diagnostic testing if medically necessary. A copy of the written report shall be served on the employee and the person designated by the MPN applicant within 20 days of the date of the appointment or receipt of the results of the diagnostic tests, whichever is later.

If the injured covered employee disagrees with the diagnosis or treatment of the third opinion physician, the injured employee may file with the Administrative Director a request for an Independent Medical Review.

8. Section 9767.8 Modification of Medical Provider Network Plan

This section provides that the MPN applicant shall serve the Administrative Director with a Notice of MPN Plan Modification before effecting any of the following changes: (1) a change of 10% or more in the providers participating in the network; (2) a change in the continuity of care policy; (3) a change in policy or procedure that is used by the applicant to conduct "economic

profiling of MPN providers” pursuant to Labor Code section 4616.1; (4) a change in the name of the MPN; (5) a change of the DWC liaison; (6) a change in geographic service area; or (7) a change in how the MPN complies with the access standards.

Within 60 days of the Administrative Director’s receipt of a Notice of MPN Plan Modification, the Administrative Director shall approve or disapprove the plan change based on information provided in the Notice of MPN Plan Modification. If the Administrative Director has not acted on a plan within 60 days of submittal of a Notice of MPN Plan Modification, it shall be deemed approved. This section also sets forth the reconsideration procedures for the MPN applicant if the MPN Plan Modification is not approved.

9. Section 9767.9 Transfer of Ongoing Care into the MPN

This section provides the procedure for the transfer of ongoing care into the MPN. If an injured covered employee is being treated for an occupational injury or illness by a physician or provider prior to coverage of a medical provider network, and the employee’s physician or provider becomes a provider within the MPN that applies to the injured employee, then the MPN applicant shall inform the employee and his or her physician that his/her treatment is being provided by his/her physician or provider under the provisions of the MPN.

This section requires the insurer or employer to provide for the completion of treatment for injured employees who are being treated by a physician or provider outside of the MPN for an occupational injury or illness that occurred prior to the coverage of the MPN and whose treating physician is not a provider within the MPN, including injured employees who pre-designated a physician and do not fall within the Labor Code section 4600(d), for the following conditions: (1) an acute condition; (2) a serious chronic condition; (3) a terminal illness; or (4) performance of a surgery or other procedure that is authorized by the insurer or employer. The regulation defines these conditions. The regulations also states that referrals made to providers subsequent to the inception of the MPN shall be made to a provider within the MPN.

Following determination of the injured employee’s medical condition, the regulation provides that the insurer or employer shall notify the employee of the determination regarding the completion of treatment. The notification shall be sent to the employee’s residence and a copy of the notification shall be sent to the employee’s primary treating physician. The notification shall be written in English and Spanish.

The section also provides that if the injured employee disputes the medical determination under this section, the injured employee shall request a report from the employee’s primary treating physician that addresses whether the employee falls within any of the four conditions set forth above. Finally, the section provides the procedure if there is a dispute regarding the medical determination and whether the transfer of care will go forward during the dispute resolution process.

10. Section 9767.10 Continuity of Care Policy

This section requires an insurer or employer that offers a medical provider network to complete the treatment by a terminated provider as set forth in Labor Code sections 4616.2(d) and (e).

11. Section 9767.11 Economic Profiling Policy

This section provides that an insurer's or employer's filing of its economic profiling policies and procedures shall include: (1) an overall description of the profiling methodology, data used to create the profile and risk adjustment; (2) a description of how economic profiling is used in utilization review; (3) a description of how economic profiling is used in peer review; and (4) a description of any incentives and penalties used in the program and in provider retention and termination decisions.

12. Section 9767.12 Employee Notification.

This section sets forth the requirements for the employee notifications concerning medical provider networks. An insurer or employer that offers a Medical Provider Network is required to notify each employee in writing about the use of the Medical Provider Network prior to the implementation of an approved MPN, at the time of hire, or when an existing employee transfers into the MPN, whichever is appropriate to ensure that the employee has received the initial notification. The notification shall also be sent to the employee at the time of injury. The notification shall be written in English and Spanish.

The initial written notification shall include the following information: (1) the name of the person designated by the applicant to be the MPN contact for covered employees; (2) a description of MPN services; (3) how to review, receive or access the MPN provider directory; (4) how to access initial care and subsequent care; (5) how to choose a physician within the MPN; (6) what to do if a covered employee has trouble getting an appointment with a provider within the MPN; (7) how to change a physician within the MPN; (8) how to obtain a referral to a specialist; (9) how to use the 2nd and 3rd opinion process; (10) how to request and receive an independent medical review; (11) a description of the standards for transfer of ongoing care into the MPN; and (12) a copy of the continuity of care policy as required by Labor Code section 4616.2.

This section also provides that at the time of the selection of the physician for a third opinion, the covered employee shall be notified about the Independent Medical Review process. Finally, a covered employee shall be notified 30 days prior to a change of the medical provider network and a copy of the notification shall be served on the employer. The notifications shall be written in English and Spanish.

13. Section 9767.13 Denial of Approval of Application and Reconsideration

This section provides that the Administrative Director shall deny approval of a plan if the MPN applicant does not satisfy the requirements of this article and Labor Code section 4616 et seq., shall state the reasons for disapproval in writing in a Notice of Disapproval, and shall transmit the Notice to the MPN applicant by U.S. Mail.

An MPN applicant denied approval may either submit a new application addressing the deficiencies or request reconsideration by the Administrative Director. The regulations sets for the procedure for a request for reconsideration and the hearing process.

14. Section 9767.14 Suspension or Revocation of Medical Provider Network Plan; Hearing

Subdivision (a) of this regulation provides that the Administrative Director may suspend or revoke approval of a MPN if: (1) service under the MPN is not being provided according to the terms of the approved MPN plan; (2) the MPN fails to meet the requirements of Labor Code section 4616 et seq. and this article; (3) false or misleading information is knowingly or repeatedly submitted by the MPN or a participating provider or the MPN knowingly or repeatedly fails to report information required by this article; or (4) the MPN knowingly continues to use the services of a provider or medical reviewer whose license, registration, or certification has been suspended or revoked or who is otherwise ineligible to provide treatment to an injured worker under California law.

This section also provides that 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 specify the time period in which the suspension or revocation will take effect.

The regulation also provides the procedure if the MPN applicant requests reconsideration of the suspension or revocation.

MATTERS PRESCRIBED BY STATUTE APPLICABLE TO THE AGENCY OR TO ANY SPECIFIC REGULATION OR CLASS OF REGULATIONS

There are no other matters prescribed by statute applicable to the Division of Workers' Compensation or to any specific regulation or class of regulations.

MANDATE ON LOCAL AGENCIES OR SCHOOL DISTRICTS

None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district.

FISCAL IMPACTS

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.

Other nondiscretionary costs/savings imposed upon local agencies:

None. The establishment of a medical provider network plan is discretionary.

Costs or savings to state agencies or costs/savings in federal funding to the State:

Labor Code section 4616 requires the Administrative Director to approve the submitted medical provider network application if he or she determines that the plan meets the requirements. This new workload will impose costs to the Division of Workers' Compensation that have been addressed through the budget process and approved by the Legislature on October 7, 2004. The additional expenditures for the current year is \$630,000 and the projected costs for the next two fiscal years is \$840,000.

There is a potential savings to state agencies who are insured with State Fund Insurance Company (SCIF) if SCIF decides to establish a medical provider network.