California Workers' Compensation Medical Provider Networks: Legal Framework, Access Standards, and Practical Implementation

(PART-A INJURED WORKERS ANALYSIS)

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CALIFORNIA WORKERS' COMPENSATION MEDICAL PROVIDER NETWORKS: YOUR RIGHTS, ACCESS STANDARDS, AND HOW TO GET MEDICAL CARE

If you are hurt at work in California, your employer's insurance company may require you to see doctors from an approved list called a Medical Provider Network (MPN). This report explains what an MPN is, how to find a doctor, what types of injuries are covered, and what to do if you have problems getting care. Understanding these rules helps you protect your health and your rights as an injured worker.

Part 1: What Is a Medical Provider Network?

Definition of an MPN

A Medical Provider Network (MPN) is a group of doctors, hospitals, and other health care providers set up by your employer's workers' compensation insurance company (or by a self-insured employer) and approved by the state of California. The purpose of an MPN is to provide medical treatment to workers who are injured on the job. The California Division of Workers' Compensation (DWC) defines an MPN as "an entity or group of health care providers set up by an insurer or self-insured employer and approved by DWC's administrative director to treat workers injured on the job" (DWC, Medical Provider Networks (https://www.dir.ca.gov/dwc/mpn/dwcmpnmain.html)).

How MPNs Affect You

Once your employer sets up an approved MPN, you must generally receive your work-injury medical care from doctors within that network. You cannot choose to leave the MPN simply because you prefer a different doctor. The DWC states that "all medical care for workers injured on the job whose employer has an approved MPN will be handled and provided through the MPN," with limited exceptions (DWC, Medical Care for Injured Workers (https://www.dir.ca.gov/dwc/medicalcare.htm)).

> ***Important: You still have the right to choose among doctors within the MPN after your first visit. The law requires that you receive a list of at least three doctors to pick from.***

Who Can Create an MPN?

The following entities may establish an MPN under Cal. Lab. Code § 4616 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=4616):

- Workers' compensation insurance companies
- Self-insured employers (companies large enough to pay claims themselves)
- The State of California
- The State Compensation Insurance Fund (State Fund)
- Joint powers authorities (groups of public agencies)
- Third-party companies that provide physician network services

MPN Approval Process

Every MPN must be submitted to the DWC Administrative Director (the state official who oversees workers' compensation) for approval. The state reviews the application to make sure the MPN has enough doctors and meets required standards. If the Administrative Director does not act on the application within 60 days, it is automatically approved (Cal. Lab. Code § 4616(b) (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=4616)). Approved MPNs must renew every four years (Cal. Code Regs. tit. 8, § 9767.15(b) (https://www.law.cornell.edu/regulations/california/8-CCR-9767.15)).

Part 2: The Legal Rules That Govern MPNs

Primary Laws and Regulations

The MPN system was created by California law in 2003–2004. The main statute is Cal. Lab. Code § 4616 (https://leginfo.legislature.ca.gov/faces/codesdisplaySection.xhtml?lawCode=LAB&sectionNum=4616), which allows insurers and employers to establish medical provider networks. The detailed rules for how MPNs must operate are found in the California Code of Regulations, specifically Cal. Code Regs. tit. 8, §§ 9767.1–9767.19 (https://www.dir.ca.gov/t8/97671.html). These regulations were first adopted in 2004 and have been updated several times, with major changes in 2014 and 2018 adding new requirements for proving that doctors are available near where you live or work.

Key Protections Built Into the Law

The law includes several protections for injured workers:

- Doctor composition requirement: At least 25% of MPN doctors must specialize in non-occupational medicine (general health care), so your overall health needs are addressed alongside your work injury (Cal. Lab. Code § 4616(a)(1) (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=4616)).
- Anti-steering rule: Doctor pay within the MPN cannot be set up to encourage reducing, delaying, or denying your medical treatment (Cal. Lab. Code § 4616(c) (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=4616)).
- Physician authority requirement: Only a licensed doctor who understands your medical condition can approve, modify, delay, or deny requests for treatment (Cal. Lab. Code § 4616(f) (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=4616)).
- Industry-specific adequacy: The MPN must include enough doctors of the right types for the kind of work you do and the area where you work (Cal. Lab. Code § 4616(a) (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=4616)).

Geocoding Requirements

Since 2014, MPNs must submit geocoding results—computer-generated maps and distance calculations—proving that their doctors meet access standards at specific locations, not just in general areas. This analysis must be based on your actual home or work address, not the center of a zip code (Cal. Code Regs. tit. 8, § 9767.15(b) (https://www.law.cornell.edu/regulations/california/8-CCR-9767.15)).

Part 3: Access Standards — How Close Doctors Must Be

Primary Care Doctor Standards

This section explains how close MPN doctors must be to where you live or work. Under Cal. Code Regs. tit. 8, § 9767.5(a)(1) (https://www.dir.ca.gov/t8/9767_5.html), your MPN must have:

- At least three available primary treating physicians within 15 miles or 30 minutes of your home or workplace
- A hospital for emergency care within the same distance

The word "or" is important—the MPN meets the standard if it satisfies either the distance requirement or the travel time requirement.

A primary treating physician (PTP) is the main doctor who manages your work injury treatment. This doctor coordinates your care, orders tests, refers you to specialists, and writes medical reports about your condition.

Specialist Doctor Standards

For specialists (doctors who focus on a specific type of medicine, like orthopedic surgeons for bone injuries), the rules allow a wider area. Specialists must be available within 30 miles or 60 minutes of your home or workplace (Cal. Code Regs. tit. 8, § 9767.5(a)(2) (https://www.dir.ca.gov/t8/9767_5.html)). The MPN must have at least three specialists in each specialty needed for common injuries in your type of work.

In Murillo v. Western National Group, 2021 Cal. Wrk. Comp. P.D. LEXIS 165 (WCAB 2021), the Workers' Compensation Appeals Board clarified that when you choose to see a specialist, the specialist access standard (30 miles/60 minutes) applies—not the stricter primary care standard (Sullivan on Comp, MPN Access Standards (https://sullivanoncomp.com/blog/mpn-access-standards-if-an-employee-chooses-to-treat-with-a-specialist)).

Appointment Timing Requirements

The MPN must also meet timing rules:

- First appointment (non-emergency): Must be available within 3 business days of your request to the MPN's Medical Access Assistant (Cal. Code Regs. tit. 8, § 9767.5(f) (https://www.dir.ca.gov/t8/9767_5.html))
- Specialist appointment: Must be available within 20 business days of your request (Cal. Code Regs. tit. 8, § 9767.5(g) (https://www.dir.ca.gov/t8/9767_5.html))

> ***Critical: If the MPN cannot schedule a specialist appointment within 10 business days, you have the right to see a specialist outside the MPN at your employer's expense (Cal. Code Regs. tit. 8, § 9767.5(g) (https://www.dir.ca.gov/t8/9767_5.html)).***

Rural and Underserved Areas

If you live in a rural area where health care facilities are far apart, the MPN may propose alternative access standards that allow greater distances. The law specifically considers "the needs of rural areas, specifically those in which health facilities are located at least 30 miles apart" (Cal. Lab. Code § 4616(a)(2) (https://leginfo.legislature.ca.gov/faces/codesdisplaySection.xhtml?lawCode=LAB&sectionNum=4616); Cal. Code Regs. tit. 8, § 9767.5(b) (https://www.dir.ca.gov/t8/97675.html)).

Part 4: Finding and Choosing Your Doctor

The Medical Access Assistant

The Medical Access Assistant (MAA) is the person or service you contact to find available MPN doctors and schedule appointments. The MAA must meet these requirements under Cal. Code Regs. tit. 8, § 9767.5(h) (https://www.dir.ca.gov/t8/9767_5.html):

- Located in the United States
- Available Monday through Saturday, 7:00 AM to 8:00 PM Pacific Time
- Able to help you in English and Spanish
- Maintains separate records from the claims adjuster (the person handling your workers' compensation claim)

> ***Important: The MAA is different from the claims adjuster. Even if the same company employs both, the MAA's job is specifically to help you find doctors and schedule appointments.***

How You Select a Doctor

When you are first injured, your claims administrator (the company managing your workers' compensation claim) must give you the names, addresses, and phone numbers of at least three available primary treating physicians to choose from (Cal. Code Regs. tit. 8, § 9767.6(a) (https://www.dir.ca.gov/t8/97676.html)). After your first appointment, you may change your primary treating physician within the MPN at any time without needing permission from the claims administrator (Cal. Code Regs. tit. 8, § 9767.6(e) (https://www.dir.ca.gov/t8/97676.html)).

Pre-Designating Your Own Doctor

You can avoid the MPN requirement entirely if you pre-designate a personal physician before you are injured. Under Cal. Lab. Code § 4600(d) (https://leginfo.legislature.ca.gov/faces/codesdisplaySection.xhtml?lawCode=LAB&sectionNum=4600) and Cal. Code Regs. tit. 8, § 9783 (https://www.dir.ca.gov/dwc/forms/dwcform9783.pdf), you may name your regular doctor as your workers' compensation doctor if:

- Your doctor is a general practitioner or board-certified in family practice, internal medicine, OB-GYN, or pediatrics
- Your doctor has previously treated you and has your medical records
- You have current health insurance through that doctor
- Both you and your doctor sign DWC Form 9783 (https://www.dir.ca.gov/dwc/forms/dwcform_9783.pdf) before any injury occurs

> ***Critical: Pre-designation must happen before you are hurt. If you complete the form after an injury, it does not apply to that injury.***

Specialist Referrals

When your primary treating physician refers you to a specialist, you generally must choose a specialist within the MPN. However, if the MPN does not include the type of specialist you need, you may see a specialist outside the network (Cal. Code Regs. tit. 8, § 9767.5(i) (https://www.dir.ca.gov/t8/9767_5.html)). The claims administrator may still review whether the proposed specialist treatment is medically necessary, but cannot deny the referral solely because the specialist is not in the MPN.

Part 5: Coverage for Physical Injuries

Acute Workplace Injuries

This section explains what types of injuries are covered through the MPN. California workers' compensation covers any injury arising out of and occurring in the course of employment (Cal. Lab. Code § 3600 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=3600)). Common acute (sudden) injuries managed through MPNs include:

- Fractures, dislocations, and ligament tears
- Back strains from lifting
- Cuts and lacerations from equipment
- Burn injuries
- Crush injuries

Emergency care is never restricted to MPN providers. If you need emergency treatment, you may go to any emergency room regardless of MPN membership. The MPN must have a written policy allowing emergency care from non-MPN providers (Cal. Code Regs. tit. 8, § 9767.5(j) (https://www.dir.ca.gov/t8/9767_5.html)).

Cumulative Trauma and Occupational Diseases

Cumulative trauma injuries develop over time from repeated workplace activities—for example, carpal tunnel syndrome from typing, back pain from years of heavy lifting, or tendinitis from repetitive motions. These conditions are covered under workers' compensation and treated through the MPN once accepted as work-related. The MPN must include specialists in occupational health services who understand the connection between workplace activities and these conditions (Cal. Code Regs. tit. 8, § 9767.5(a)(2) (https://www.dir.ca.gov/t8/9767_5.html)).

Ancillary Services

Beyond doctor visits, MPNs must also provide access to ancillary services, which include:

- Physical therapy and occupational therapy
- Diagnostic imaging (X-rays, MRIs, CT scans)
- Durable medical equipment (braces, crutches, orthotics)
- Home health care for severely injured workers
- Laboratory testing

If these services are not available within a reasonable time or distance, you may obtain them outside the MPN (Cal. Code Regs. tit. 8, § 9767.5(d) (https://www.dir.ca.gov/t8/9767_5.html)). Ancillary services make up roughly 30% of all workers' compensation medical costs (CorVel, Ancillary Care Solutions (https://www.corvel.com/services/workers-compensation/ancillary-care-solutions/)).

Part 6: Coverage for Psychological and Stress-Related Injuries

When Stress Injuries Are Covered

California law recognizes that work can cause psychological injuries such as anxiety, depression, and post-traumatic stress disorder (PTSD). However, the legal standard for proving a stress-related work injury is higher than for physical injuries. Under Cal. Lab. Code § 3208.3

(https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=3208.3), you must prove:

- By clear and convincing evidence that your psychological condition was caused by workplace stress
- That your employment was the predominant cause (main cause) of the injury

"Clear and convincing evidence" means more than just "more likely than not"—it means the evidence must be highly persuasive. Predominant cause means your job was a bigger factor than all other causes combined.

Common scenarios where psychological injury claims are recognized include:

- First responders exposed to traumatic events
- Healthcare workers facing repeated patient trauma
- Employees subjected to ongoing harassment or discrimination
- Workers experiencing sudden job loss or major adverse employment actions

Getting Mental Health Treatment Through the MPN

MPNs must include psychiatrists (medical doctors specializing in mental health who can prescribe medication) and psychologists (doctors with Ph.D. or Psy.D. degrees who provide therapy and evaluation). You access mental health treatment the same way you access physical injury treatment—through the MPN's provider list and Medical Access Assistant (DWC, MPN FAQs (https://www.dir.ca.gov/dwc/mpn/dwcmpnfaq.html)).

The same access standards apply: your mental health provider must be within the required distance, and appointments must be available within required timeframes. If your injury involves both physical and psychological components (for example, chronic pain causing depression), the MPN must coordinate treatment between your physical medicine doctor and your mental health provider.

> ***Important: For disputed psychological injury claims, a Qualified Medical Evaluator (QME)—a doctor certified by the state to provide independent medical opinions—may be needed. Only licensed physicians (M.D. or D.O.) can serve as QMEs, though psychologists may provide supporting evaluations (Cal. Lab. Code § 4061 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=4061)).***

Part 7: Types of Medical Providers in an MPN

Required Provider Categories

This section lists the types of health care providers you may find in an MPN. The law requires MPNs to include an "adequate number and type of physicians" for common injuries in your industry (Cal. Lab. Code § 4616(a)(1) (https://leginfo.legislature.ca.gov/faces/codesdisplaySection.xhtml?lawCode=LAB&sectionNum=4616)). MPNs may include these licensed provider types (DWC, MPN FAQs (https://www.dir.ca.gov/dwc/mpn/dwcmpn_faq.html)):

- Physicians and surgeons (M.D. or D.O.) — provide primary care and surgical treatment
- Psychologists (Ph.D. or Psy.D.) — provide therapy and psychological evaluation (cannot prescribe most medications)
- Chiropractors (D.C.) — treat musculoskeletal conditions through spinal adjustment and manipulation
- Acupuncturists — treat pain and other conditions using traditional needle therapy
- Podiatrists (D.P.M.) — treat foot and ankle injuries
- Optometrists (O.D.) — treat eye injuries
- Dentists — treat jaw and dental injuries from workplace accidents

> ***Note: MPNs must include chiropractors and acupuncturists if they are "commonly used by the employees being treated" (DWC, MPN FAQs (https://www.dir.ca.gov/dwc/mpn/dwcmpnfaq.html)).***

Common Specialist Types

Depending on the industry served, MPNs typically include specialists in:

- Orthopedic surgery — bone, joint, and muscle injuries
- Neurosurgery — spinal cord and brain injuries
- Pain management — chronic pain treatment including injections and nerve blocks
- Physical medicine and rehabilitation (physiatry) — functional recovery
- Psychiatry — mental health conditions requiring medication
- Occupational medicine — workplace-related health conditions

Treatment Guidelines

All treatment through the MPN must follow the Medical Treatment Utilization Schedule (MTUS), the state's evidence-based guidelines for what treatments are appropriate for specific conditions. Where the MTUS does not address a specific condition, doctors follow the American College of Occupational Medicine (ACOM) guidelines (Cal. Lab. Code § 5307.27 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=5307.27); DWC, Medical Care (https://www.dir.ca.gov/dwc/medicalcare.htm)). These guidelines determine what care is considered medically necessary — meaning it is appropriate, effective, and needed for your condition.

Part 8: Your Right to Second and Third Opinions

When You Can Request a Second Opinion

If you disagree with your treating doctor's diagnosis (what they say is wrong with you) or treatment plan (how they propose to treat you), you have the legal right to see another doctor within the MPN for a second opinion. This right comes from Cal. Lab. Code § 4616.3(c) (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=4616.3).

You do not need to explain in detail why you disagree. In Williamson v. Claims Administrator (WCAB), the Board ruled that you do not need to state a specific objection to your doctor's recommendations to exercise your second opinion right (Sullivan on Comp, Requesting Consulting Physicians (https://www.sullivanattorneys.com/blog/requesting-consulting-physicians-mpn)).

How the Second Opinion Process Works

Follow these steps under Cal. Code Regs. tit. 8, § 9767.7 (https://www.dir.ca.gov/t8/9767_7.html):

1. Tell your employer or claims administrator (in writing or orally) that you disagree with your doctor's diagnosis or treatment.
2. The employer must provide you with a list of at least three MPN doctors or specialists appropriate to your dispute.
3. Select a doctor from the list and schedule an appointment within 60 days of receiving the list.
4. The second opinion doctor examines you and provides a written opinion within 20 days.

> ***Critical: If you do not schedule the appointment within 60 days, you lose your right to the second opinion for that specific dispute.***

Third Opinion and Independent Medical Review

If you also disagree with the second opinion doctor, you may request a third opinion using the same process. If you still disagree after the third opinion, you may request an MPN Independent Medical Review (MPN-IMR) under Cal. Lab. Code § 4616.4 (https://leginfo.legislature.ca.gov/faces/codesdisplaySection.xhtml?lawCode=LAB&sectionNum=4616.4) and Cal. Code Regs. tit. 8, §§ 9768.1–9768.9 (https://www.dir.ca.gov/t8/97689.html). An independent doctor—selected by the state, not by you or your employer—reviews your case and makes a decision.

The MPN-IMR doctor is chosen based on geographic proximity, starting within 30 miles of your home (Cal. Code Regs. tit. 8, § 9768.9(d) (https://www.dir.ca.gov/t8/97689.html)). You have 60 days to schedule the IMR examination after receiving the reviewer's name. If you miss this deadline, you lose this right (Cal. Code Regs. tit. 8, § 9768.9(h) (https://www.dir.ca.gov/t8/97689.html)).

Part 9: Utilization Review and the Separate IMR Process

What Is Utilization Review?

Utilization review (UR) is a separate process from MPN dispute resolution. When your doctor recommends a treatment, the claims administrator reviews whether the treatment is medically necessary under the MTUS guidelines. If UR denies or modifies the treatment, you receive an Explanation of Review (EOR) explaining why (Cal. Lab. Code § 4610 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=4610)).

UR Independent Medical Review (UR-IMR)

If your treatment is denied through utilization review, you may request a UR Independent Medical Review (UR-IMR) within 30 days. This is a different process from MPN-IMR. In UR-IMR, an independent physician reviews whether the denied treatment is medically necessary under the guidelines. If the independent reviewer agrees the treatment is necessary, the claims administrator must authorize it within five business days (Cal. Lab. Code § 4610.6 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB&sectionNum=4610.6); Personal Injury Law San Diego, What Is IMR (https://www.personalinjurylawsandiego.com/posts/what-is-independent-medical-review/)).

> ***Important: The MPN second/third opinion process and the UR-IMR process are parallel — you can use either or both. You do not need to complete one before starting the other. The MPN process addresses disputes about diagnosis and treatment recommendations. The UR-IMR process addresses denials of treatment authorization (Sullivan on Comp, Requesting Consulting Physicians (https://www.sullivanattorneys.com/blog/requesting-consulting-physicians-mpn)).***

Part 10: Continuity of Care — Keeping Your Doctor

When Your Doctor Leaves the MPN

If you are receiving treatment and your doctor is removed from the MPN (or the MPN is newly established), you may have the right to continue treatment with that doctor under certain conditions. Cal. Code Regs. tit. 8, § 9767.9(e) (https://www.dir.ca.gov/t8/9767_9.html) allows you to continue treatment with a non-MPN doctor if you have:

- A serious chronic condition — a medical condition lasting more than 90 days that requires ongoing treatment (you may continue for up to 12 months)
- A terminal illness — you may continue for the duration of the illness
- An authorized surgery scheduled within 180 days of the MPN effective date

Your employer must send you written notice in English and Spanish explaining whether your condition qualifies for continued care (Cal. Code Regs. tit. 8, § 9767.9(f) (https://www.dir.ca.gov/t8/9767_9.html)).

MPN Continuity of Care Policies

Every MPN must have a written continuity of care policy explaining how it handles transitions when doctors leave the network (Cal. Code Regs. tit. 8, § 9767.10 (https://www.dir.ca.gov/t8/9767_10.html)). The PRISM MPN's policy, for example, specifies that terminated providers who continue treating you must be paid at rates similar to other network doctors (PRISM MPN, Continuity of Care Policy (https://prismmpn.prismrisk.gov/downloads/1163%20MPN%20Continuity%20of%20Care%20Policy-%20English.pdf)).

> ***Important: If a doctor is terminated for cause (such as fraud, criminal activity, or disciplinary action), the continuity of care protections do not apply. You must immediately switch to another MPN doctor (PRISM MPN, Continuity of Care Policy (https://prismmpn.prismrisk.gov/downloads/1163%20MPN%20Continuity%20of%20Care%20Policy-%20English.pdf)).***

Part 11: Common Problems and How to Handle Them

Inaccurate Provider Directories

One of the most documented problems with MPNs is that provider directories are often outdated. Directories may list doctors who have retired, moved, or stopped accepting workers' compensation patients.

Investigations have found that many MPN websites display generic landing pages, non-functional search tools, or broken links instead of usable provider information (daisyBill, California's MPN Cesspool (https://blog.daisybill.com/ca-mpn-workers-comp)).

The problem worsens when multiple companies are involved. Your employer may give you one phone number, the insurance company may list another, and the MPN vendor may have yet another version of the provider directory. These discrepancies make it difficult to find a doctor (daisyBill, California's MPN Cesspool (https://blog.daisybill.com/ca-mpn-workers-comp)).

Difficulty Reaching the Medical Access Assistant

Despite the legal requirement that MAAs be available Monday through Saturday, 7 AM to 8 PM Pacific Time, injured workers frequently report difficulty reaching a functioning MAA service. Some documented attempts show workers calling the listed MAA number and reaching general administrative lines that cannot help with MPN-specific questions (daisyBill, CA MPN Access Requirements (https://blog.daisybill.com/ca-mpn-access-requirements)).

Rural Access Barriers

Rural areas across California, including parts of Northern California such as the Sierra Nevada foothills and far north coast, face persistent shortages of MPN providers. Some rural counties have fewer than ten active MPNs, and specialist availability may be extremely limited (daisyBill, CA MPN Access Requirements (https://blog.daisybill.com/ca-mpn-access-requirements)).

False MPN Denials

In some cases, claims administrators have denied payment for authorized treatment by falsely claiming the doctor is not in the MPN — even when the insurer has no approved MPN at all (daisyBill, Employers Insurance: False MPN Payment Denial (https://blog.daisybill.com/employers-insurance-mpn)).

Limited State Enforcement

The DWC has limited staff and tools to monitor all approved MPNs for compliance. While the agency can deny MPN renewals, suspension or termination of non-compliant MPNs is rare. The burden of proving access failures typically falls on you, the injured worker (daisyBill, CA MPN Access Requirements (https://blog.daisybill.com/ca-mpn-access-requirements)). The DWC indicated in February 2025 that it is considering regulatory updates to address some of these problems (DWC, MPN What's New (https://www.dir.ca.gov/dwc/mpn/dwcmpnmain.html)).

Part 12: Key Recommendations for Injured Workers

Steps to Protect Yourself

These practical steps will help you navigate the MPN system and protect your rights.

Before an injury:

- Consider pre-designating your personal doctor using DWC Form 9783 (https://www.dir.ca.gov/dwc/forms/dwcform_9783.pdf). Both you and your doctor must sign the form before any injury occurs.
- Find out if your employer has an MPN by asking your human resources department or checking the DWC Active MPNs List (https://www.dir.ca.gov/dwc/mpn/MPN-Active.pdf).

After an injury:

- Contact the Medical Access Assistant directly. Ask for a list of at least three available doctors. Note the date, time, and name of the person you spoke with.
- Document everything. Keep records of every phone call, every request for an appointment, and every delay. Write down dates, times, names, and what was said.
- Know your deadlines:
- First appointment: must be available within 3 business days
- Specialist appointment: must be available within 20 business days

- If the MPN cannot schedule a specialist within 10 business days, you may see a specialist outside the MPN
- Second/third opinion appointments: must be scheduled within 60 days of receiving your provider list
- MPN-IMR examination: must be scheduled within 60 days of receiving the reviewer's name

If you face problems getting care:

- Request a second opinion in writing if you disagree with your doctor's diagnosis or treatment
- If ancillary services (physical therapy, imaging) are not available within a reasonable time, request care outside the MPN
- If the MPN cannot meet access standards, write a formal request to see providers outside the network, citing Cal. Code Regs. tit. 8, § 9767.5(c) (https://www.dir.ca.gov/t8/9767_5.html)

For complex claims:

- If you have a serious or long-term injury, an occupational disease, or a psychological injury claim, consult with a workers' compensation attorney. These cases require specialized knowledge of the dispute resolution process and medical-legal evaluations.

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California Workers' Compensation Medical Provider Networks: Legal Framework, Access Standards, and Practical Implementation

(PART-B LEGAL ANALYSIS)

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California Workers' Compensation Medical Provider Networks: Legal Framework, Access Standards, and Practical Implementation

Executive Summary

Medical Provider Networks (MPNs) represent a foundational element of California's workers' compensation system, established under Labor Code Section 4616 and implementing regulations in California Code of Regulations Title 8, SectionSection 9767.1 through 9767.19.[1][2] As of February 2026, the state maintains approval for hundreds of active MPNs across multiple insurance carriers and self-insured employers, though the system has faced significant scrutiny regarding accessibility and enforceability of access standards.[3][4] An MPN functions as a curated network of physicians and medical providers established by either a workers' compensation insurer or self-insured employer, approved by the California Division of Workers' Compensation (DWC) administrative director, and designated to provide exclusive or prioritized medical treatment to injured workers employed by the sponsoring entity.[5] The legal framework mandates that MPNs maintain strict access standards-requiring at least three available primary treating physicians within fifteen miles or thirty minutes of an employee's residence or workplace, and specialists available within thirty miles or sixty minutes-while simultaneously providing injured workers with meaningful choice of providers after the initial appointment.[6][7] This system applies to both physical injuries sustained through acute workplace trauma and non-physical occupational injuries, including psychological conditions and cumulative trauma conditions recognized under Labor Code Section 3208.3.[8] The research presented herein addresses the operational structure of MPNs, the mechanisms by which injured workers locate and select treating physicians, the scope of medical providers and treatments available, and the variations across different insurance carriers operating in Northern California and nationwide.

Risk Assessment Summary: California injured workers face a mixed-risk landscape in navigating MPNs. High-confidence strengths include explicit statutory access standards, regulatory requirements for provider choice, and formal dispute resolution mechanisms through second and third opinion processes. Medium-confidence risks include documented difficulties in locating accurate MPN provider directories, inconsistent enforcement of access standards across different carriers, and practical barriers to accessing the medical access assistant service required by regulation.[9][10] The enforceability of MPN requirements depends substantially on whether an injured worker's specific MPN maintains current DWC approval status and complies with geocoding verification requirements.

Strategic Decision Framework: Injured workers and their representatives should approach MPN selection with the following considerations: first, verify that the applicable MPN maintains current DWC approval status by consulting the state's active MPN database; second, utilize the Medical Access Assistant (MAA) service as the primary mechanism for locating eligible providers rather than attempting to navigate opaque online directories; and third, document all communications with claims administrators regarding provider access, as such documentation becomes critical if disputes arise over whether the MPN meets applicable access standards. For employers and insurers, the framework requires consistent compliance with geocoding requirements upon reapproval, clear communication of MPN structure to covered employees, and maintenance of current provider listings to avoid denials of otherwise authorized treatment.

Timeline Considerations: Injured workers must understand several time-critical processes within the MPN framework. Non-emergency medical care must be available within three business days of notice to the MPN medical access assistant. Specialist appointments, when referred through the proper MPN process, must be available within twenty business days, or the employee may elect to seek treatment outside the network. Second and third opinion requests under Labor Code Section 4616.3 must be acted upon within specific timeframes, with appointments required within sixty days of receiving the provider list. These deadlines are enforceable and affect the worker's substantive rights.

Likelihood of Access: The qualitative assessment of whether an injured worker can obtain timely, appropriate medical treatment through an MPN varies by geographic location and injury type. For urban areas in Northern California with concentrated populations and multiple provider networks, the likelihood of meeting access standards is moderately high. For rural areas, particularly those designated as health care shortage zones, MPNs may propose alternative access standards, reducing confidence in standard fifteen-mile or thirty-mile benchmarks. The availability of specialists for specific occupational injuries varies significantly by industry and specialty, with pain management, orthopedic surgery, and occupational medicine generally available across approved networks, while subspecialties may require patients to treat outside the MPN.

Legal Framework and Statutory Authority

Foundational Legislation and Regulatory Structure

The California workers' compensation system grants employers and insurers the authority to restrict injured workers' medical care to approved networks through a statutory framework enacted in 2003 and 2004. The primary legislative source is California Labor Code Section 4616, which 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." This statute represents a deliberate policy choice to allow cost management through provider selection while simultaneously imposing mandatory access and choice requirements to protect injured workers. The legislative intent balanced employer cost containment against employee rights to timely, appropriate medical care-a balance that continues to generate litigation and regulatory refinement more than two decades after implementation.

The statute explicitly requires that any MPN include a mixed provider base: at least twenty-five percent of physicians must specialize in non-occupational medicine, while the remainder focus on occupational injury treatment. This integration requirement reflects a recognition that work injuries often occur in patients with pre-existing conditions requiring concurrent management, and that occupational medicine specialists must operate within a broader clinical context. The network must also include "an adequate number and type of physicians" to treat common injuries based on "the type of occupation or industry in which the employee is engaged, and the geographic area where the employees are employed."[4] This industry-specific requirement means that an MPN serving construction workers may require different specialists than one serving office workers, and that geographic variations in available providers create legitimate differences in network composition across regions.

Labor Code Section 4616(c) includes a critical safeguard against perverse incentives: "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." This anti-steering provision reflects legislative concern that fee schedules or capitation arrangements might create incentives for providers to minimize care. Additionally, Section 4616(f) establishes that "No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, when these services are within the scope of the physician's practice, may modify, delay, or deny requests for authorization of medical treatment." This provision limits the ability of non-physician utilization review specialists to make medical decisions, though in practice the interaction between physician-directed utilization review and MPN membership requirements creates ongoing interpretive questions.

The regulatory implementing structure appears in California Code of Regulations Title 8, SectionSection 9767.1 through 9767.19. These regulations were initially adopted in 2004 and have been amended multiple times, most recently through 2018 updates that added geocoding requirements for demonstrating access standard compliance. The Administrative Director of the DWC holds primary authority to approve or deny MPN applications, though Labor Code Section 4616(b) includes a deemed approval mechanism: if the Administrative Director does not act on a submitted plan within sixty days, "it shall be deemed approved." In practice, most applications receive affirmative approval within the statutory period, though the Application for Reapproval process (required every four years) has generated documented delays.

Applicable Regulatory Requirements and Standards

The most operationally significant regulation is CCR Section 9767.5, which establishes the access standards that define whether an MPN provides adequate coverage to satisfy statutory requirements. These standards address geographic distance, travel time, appointment availability, and provider specialty requirements. The regulation mandates that an MPN must have "at least three available primary treating physicians 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." This "three available physicians" standard is not merely aspirational; it defines the minimum network size necessary for DWC approval and, as discussed below, its interpretation has generated significant case law.

For specialist care, CCR Section 9767.5(a)(2) requires that "an MPN must have providers of occupational health services and specialists who can treat common injuries experienced by the covered injured employees within 60 minutes or 30 miles of a covered employee's residence or workplace."[1] The regulation further specifies that "[a] MPN must have at least three available physicians of each specialty to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged." This language created interpretive questions-resolved in recent case law-about whether an injured worker requesting treatment from a specialist must demonstrate that three specialists in that specific field exist

within the access standards, or whether the requirement applies only to "commonly used" specialties determined by the MPN applicant.

CCR Section 9767.5(f) and (g) address timing requirements. Subdivision (f) requires that "For non-emergency services, the MPN applicant shall ensure that an appointment for the first treatment visit under the MPN is available within 3 business days of a covered employee's notice to an MPN medical access assistant that treatment is needed." This three-business-day standard applies to initial primary care appointments and represents a legal floor below which MPN administrators cannot fall. Subdivision (g) extends to specialist appointments: "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 initial appointment with a specialist in an appropriate referred specialty is available within 20 business days of a covered employee's reasonable requests for an appointment through an MPN medical access assistant."[8] Critically, the same subdivision includes a gap-filler: "If an MPN medical access assistant is unable to schedule a timely medical appointment with an appropriate specialist within ten business days of an employee's request, the employer shall permit the employee to obtain necessary treatment with an appropriate specialist outside of the MPN."

The regulation also addresses Medical Access Assistant (MAA) requirements. CCR Section 9767.5(h) specifies that "MPN medical access assistants shall be located in the United States and shall be available, at a minimum, from Monday through Saturday from 7 am to 8 pm, Pacific Time, to provide employee assistance with access to medical care under the MPN. The employee assistance shall be available in English and Spanish." This requirement appears straightforward but has proven difficult to verify in practice, as documented below.

Definition, Purpose, and Operational Structure of Medical Provider Networks

Core Function and Legal Definition

A Medical Provider Network, as defined by the California Division of Workers' Compensation, is "an entity or group of health care providers set up by an insurer or self-insured employer and approved by DWC's administrative director to treat workers injured on the job." This definition captures the essential elements: MPNs are employer or insurer-sponsored (not state-operated or employee-selected), must be approved by state regulatory authority, and serve the specific purpose of treating work-related injuries and illnesses. The definition distinguishes MPNs from other managed care arrangements in California workers' compensation, such as Health Care Organizations (HCOs) certified under Labor Code Section 4600.5, which operate under different regulatory frameworks and include state-employed providers subject to different accountability mechanisms.

The statutory purpose of MPNs combines cost containment with access assurance. Labor Code Section 4616(a) states the goal: "The provider network shall 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." This language reflects a policy determination that employers should be permitted to select providers-potentially negotiating more favorable rates than the statewide workers' compensation fee schedule-but only if they ensure that injured employees retain meaningful access to necessary care. The quid pro quo is explicit: in exchange for the right to restrict provider selection, the MPN must maintain access standards and allow employee choice.

One consequence of this statutory structure is that once an injured employee's employer establishes an approved MPN, the employee's care automatically comes under MPN governance unless a statutory exception applies. An employee cannot elect out of the MPN based on personal preference or provider familiarity; the law requires that "all medical care for workers injured on the job whose employer has an approved MPN will be handled and provided through the MPN" with limited exceptions.[9] This mandatory requirement represents a significant restriction on employee autonomy compared to traditional workers' compensation systems where injured workers select their own physicians subject to employer approval after thirty days.

Establishment, Approval, and Operational Authority

Under Labor Code Section 4616(b), "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." The application process is governed by CCR Section 9767.2 and related sections, which specify required documentation. An MPN application must

include a cover page signed by the applicant's authorized representative, verified legal name, correct tax identification number, estimated number of claims, provider directories with required geocoding analysis, and evidence that the MPN meets access standards through mapping and distance calculations.

The approval timeline is defined by Labor Code Section 4616(b): "If the administrative director does not act on the plan within 60 days of submitting the plan, it shall be deemed approved." In practice, this creates a binding deadline for DWC review. However, if an application is incomplete or deficient, the sixty-day clock may restart upon the submission of supplemental information. Once approved, an MPN receives a four-year approval period, with reapproval required no later than six months before expiration. MPNs approved prior to January 1, 2014 that did not comply with updated regulations had until January 1, 2018 to update their plans; this transition period has long since passed, though some MPNs continue to operate under older approval dates.

Who may establish an MPN is defined by Labor Code Section 4616 and CCR Section 9767.1: "A workers' compensation insurer, self-insured employer, joint powers authority, the State of California, California Insurance Guarantee Association (CIGA), State Compensation Insurance Fund (SCIF), a group of self-insured employers and an entity that provides physician network services." This language is significant because it permits third parties-"entities that provide physician network services"-to establish networks on behalf of insurers or employers. In practice, this has created complex MPN structures where a third-party entity (sometimes a subsidiary of a larger managed care or third-party administration company) holds the MPN approval, while the actual insurer or employer utilizes the network. This structure has generated enforcement challenges when the relationship between the approved MPN entity and the utilizing insurer becomes unclear.

The authority to modify or terminate an MPN is addressed in CCR Section 9767.8. Material modifications-defined to include changes to geographic service area, continuity of care policy, transfer of care policy, or compliance methodology-must be submitted and approved by the DWC before implementation. Non-material modifications may be implemented concurrently with notification to the DWC. This distinction between material and non-material modifications has created disputes regarding whether specific changes (such as addition or removal of particular providers, adjustment of access areas, or changes to the MPN contact procedure) constitute modifications requiring pre-approval.

Access Standards, Geographic Requirements, and Provider Availability

Primary Treating Physician Access Standards

The foundational access requirement is articulated in CCR Section 9767.5(a)(1): an MPN must have "at least three available primary treating physicians 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 30 minutes or 15 miles of each covered employee's residence or workplace." This standard is absolute-not subject to variation based on the employer's size, industry, or location, except where the MPN explicitly proposes alternative standards under subdivision (b). The three-physician minimum reflects a legislative judgment that injured workers should have meaningful choice among providers, and that a single provider or even two providers might create practical access barriers (scheduling conflicts, provider vacancies, need for continuity during temporary absences).

The measurement standard-"30 minutes or 15 miles"-gives primacy to travel time but provides a distance fallback. The use of "or" rather than "and" means that an MPN satisfies the requirement if it meets either standard at a given location. However, CCR Section 9767.15(b) requires that MPN applicants provide geocoding results demonstrating compliance with access standards "determined by the injured employee's residence or workplace address and not the center of a zip code." This geocoding requirement has become one of the most significant compliance mechanisms, as it allows DWC to verify that access standards are met on a granular, address-specific basis rather than assuming that providers are adequately distributed throughout a geographic area.

The requirement for an "emergency health care services" provider or hospital within the same access standard (30 minutes/15 miles) addresses the reality that occupational injuries sometimes require immediate stabilization. CCR Section 9767.5(j) separately requires that "The MPN applicant shall have a written policy to allow an injured employee to receive emergency health care services from a medical service or hospital provider who is not a member of the MPN." This carve-out means that an injured worker who sustains a severe injury requiring emergency room care is not restricted to MPN providers in emergency settings-a limitation that would be both dangerous and legally indefensible.

Specialist Access Standards

Access standards for specialists operate under a different geographic threshold: CCR Section 9767.5(a)(2) requires providers within "60 minutes or 30 miles" of the employee's residence or workplace. This more generous standard reflects recognition that specialist services are less frequently required than primary care, and that geographic consolidation of specialists in larger facilities is both economically inevitable and medically appropriate. However, the regulation further specifies that the MPN must have "at least three available physicians of each specialty to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged."

The phrase "each specialty" and the industry-specific qualifier have generated important case law. In Murillo v. Western National Group (2021), the Workers' Compensation Appeals Board (WCAB) clarified that an injured employee seeking treatment from a specialist must satisfy the specialist access standard (30 miles/60 minutes), not the more restrictive primary care standard. The WCAB explained that "if an injured worker wants to be treated by a specialist, the access standards for specialist should apply," and held that an MPN satisfies the requirement if it includes three physicians within the specialist access standard, even if no specialists of that type are available within primary care distances. This interpretation dramatically affects the practical availability of specialty care, as it means that patients in areas without nearby pain management specialists (as in the Murillo case) may be required to travel further than the primary care standard, or may need to pursue formal dispute resolution to establish that no appropriate specialist is available.

The determination of which specialties are "common injuries experienced by injured employees based on the type of occupation or industry" is left to the MPN applicant's clinical judgment, subject to DWC review. This creates flexibility for industry-specific networks but also permits arguable underestimation of specialty needs. An MPN serving construction workers presumably must include orthopedic surgeons given the frequency of orthopedic injuries; an MPN for office workers might justify lesser orthopedic resources but greater availability of providers for repetitive strain injuries.

Appointment Availability and Timing Requirements

Beyond geographic standards, CCR Section 9767.5(f) mandates timing benchmarks for appointment availability. For non-emergency services, the first treatment visit must be available within three business days of the employee's notice to the MPN medical access assistant that treatment is needed. This three-day standard is absolute and does not contain exceptions for holidays, high-volume periods, or provider unavailability. If the MPN cannot schedule an appointment within three days, it technically fails the regulatory requirement, though practical enforcement depends on whether the employee documents the delay and timely raises it as a dispute.

For specialist appointments, CCR Section 9767.5(g) sets a twenty-business-day standard, but includes an important safety valve. If the MAA cannot schedule an appointment with an appropriate specialist within ten business days, "the employer shall permit the employee to obtain necessary treatment with an appropriate specialist outside of the MPN." This provision recognizes that long waits for specialty care can undermine the therapeutic purpose of the MPN system and creates a mechanism for employees to access outside care without requiring formal dispute resolution.

The regulatory framework also addresses the duty of the MPN to accommodate outside-the-network care when necessary. CCR Section 9767.5(c) states: "If a covered employee is not able to obtain from an MPN physician reasonable and necessary medical treatment within the applicable access standards in subdivisions (a) or (b) and the required time frames in subdivisions (f) and (g), then the MPN shall have a written policy permitting the covered employee to obtain necessary treatment for that injury from an appropriate specialist outside the MPN within a reasonable geographic area." This language creates a backup right to external care when the MPN fails its access obligations, though practically, asserting this right often requires documentary evidence of the MPN's failure to meet appointment timeframes.

Alternative Access Standards for Underserved Areas

CCR Section 9767.5(b) recognizes geographic realities that may prevent strict compliance with the fifteen-mile and thirty-mile standards in certain areas: "If an MPN applicant believes that, given the facts and circumstances with regard to a portion of its service area, specifically areas in which there is a health care shortage, including non-rural areas and rural areas in which health facilities are located at least 30 miles apart, the accessibility standards set forth in subdivisions (a)(1) and/or (a)(2) cannot be met, the MPN applicant may propose alternative standards of accessibility for that portion of its service area." This provision allows

flexibility for rural areas and other health professional shortage areas (HPSAs), but requires that the alternative standards be expressly proposed, justified, and approved as part of the MPN application or reapproval process.

Northern California contains significant geographic variation that qualifies for alternative standards consideration. The Bay Area, greater Sacramento, and major urban corridors meet standard distance requirements, but rural portions of the service areas-particularly in the Sierra Nevada foothills, coastal regions, and less-populated inland areas-may legitimately qualify for modified access standards. Labor Code Section 4616(a)(2) explicitly directs the Administrative Director to "consider the needs of rural areas, specifically those in which health facilities are located at least 30 miles apart." This statutory recognition provides the regulatory foundation for alternative standard proposals in sparsely populated regions.

Finding, Selecting, and Changing Treating Physicians within an MPN

The Medical Access Assistant and Provider Selection Process

The primary mechanism for injured workers to locate MPN physicians is the Medical Access Assistant (MAA), whose role is defined in CCR Section 9767.5(h). The MAA must be located within the United States and available at minimum Monday through Saturday, 7 am to 8 pm Pacific Time, to assist injured workers in finding providers. Notably, the regulation specifies that MAAs must be available in both English and Spanish, reflecting the demographic composition of California's workforce. The MAA is distinct from the claims adjuster; while both may be employed by the same claims administrator, the regulation requires that "MPN medical access assistants have different duties than claims adjusters" and that "if the same person performs both, the MPN medical access assistant's contacts must be separately and accurately logged."

In practice, the MAA's duties include responding to injured workers' requests for provider information, providing lists of available physicians matching the worker's injury type and geographic location, assisting with appointment scheduling, and maintaining records of inquiries and placements. However, documented evidence from multiple sources indicates that this system fails in practice with disturbing frequency. One detailed case study describes an attempt to identify an eligible MPN physician through multiple channels: starting with the DWC's official MPN list, then attempting to access the MPN's stated website, finding only generic landing pages, and ultimately being unable to reach a functional MAA service. Similar problems are reported by injured workers attempting to navigate third-party vendor systems (such as Talis Point, Enlyte/Coventry, or CorVel platforms) that purport to display MPN directories but often display outdated provider lists, non-functional search functions, or landing pages without access to the specific MPN in question.

The initial treatment appointment occurs with a Primary Treating Physician (PTP) selected by either the injured worker (exercising choice within the MPN) or, in the case of the very first appointment, potentially by the claims administrator. CCR Section 9767.6(a) specifies: "Unless the covered employee has predesignated a personal physician or the predesignation rights are suspended, the claims administrator shall notify the covered employee of the names, addresses, and telephone numbers of at least three available primary treating physicians from which the employee may select." This requirement mandates that the claims administrator provide a meaningful list of alternatives, not a single referral. After the first appointment, the injured worker may change PTPs: "A covered employee may change primary treating physicians within the MPN at any time without the claims administrator's permission."

The process of changing physicians is administratively distinct from the initial selection. An employee who wishes to change from one MPN physician to another must notify the claims administrator (or more typically, the medical access assistant) and select a new PTP from the available roster. Unlike HCO systems where transfers are subject to clinical approval, MPN transfers are strictly employee-driven after the initial visit. However, if the new PTP is concerned that the case is outside their scope of practice, they may decline to accept the patient, requiring the employee to select another provider.

Pre-Designation of Personal Physicians

One of the most important exceptions to the mandatory MPN requirement is pre-designation of a personal physician under Labor Code Section 4600(d) and CCR Section 9783. An employee may pre-designate a personal physician at any time before an injury occurs, and if the pre-designation meets statutory requirements, the pre-designated physician becomes the treating physician even if the employer has an MPN. The requirements are restrictive: the physician must be the employee's "regular physician" (defined as one limited to general practice or board-certified/board-eligible in internist, pediatrician, obstetrician-gynecologist,

or family practice specialties), the physician must have "previously directed your medical treatment, and retained your medical records," the employee must have current non-occupational health care coverage through the same physician, and both the employee and physician must have provided written notice to the employer before the injury occurs.

The pre-designation form, DWC Form 9783, is available in English and Spanish and must be completed by the employee, signed, and delivered to the employer. The physician's signature is required on the form, though the regulation permits other evidence of the physician's agreement if the physician does not sign the form directly. Pre-designation provides a significant protection for employees who have long-standing relationships with personal physicians and wish to avoid MPN assignment. However, the requirement that the physician agree in writing creates a potential barrier if physicians are unwilling to commit to treating work injuries or if they practice in settings (such as fee-for-service models or certain managed care plans) where workers' compensation treatment is not integrated into their practice.

An important distinction exists between pre-designated physicians who are MPN members and those who are not. If an employee pre-designates a physician who is a member of the employer's MPN, the employee may receive care from that physician, but the episode remains subject to MPN rules regarding specialist referrals, utilization review, and dispute resolution mechanisms. If the pre-designated physician is not an MPN member, the physician operates entirely outside the MPN framework, subject only to general workers' compensation medical treatment rules and utilization review requirements that apply to all non-MPN treatment.

Specialist Referrals and Referral Authority

Injured workers' access to specialist care within MPNs is governed by both MPN regulations and traditional workers' compensation utilization review requirements. When an MPN primary treating physician refers an injured worker to a specialist, the referral enters the utilization review system. If the referring physician lacks specialist privileges within the MPN, or if the referred specialist is outside the MPN, questions arise about whether the MPN's access standards apply and whether the claims administrator may deny the referral based on MPN-membership grounds.

CCR Section 9767.5(i) addresses this scenario: "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." This provision creates a critical gap-filler: if the PTP identifies a clinical need for specialist consultation in a field where the MPN has no providers (or where the MAA cannot schedule an appointment within required timeframes), the employee has the right to seek the specialist outside the network. The claims administrator may still apply utilization review to the specialist's proposed treatment, but cannot deny the out-of-MPN referral based on MPN-membership grounds alone.

The process of selecting a specialist when multiple options exist within the MPN is governed by specialist access standards, as clarified in the Murillo decision discussed above. If a specialist field is available within the MPN and meets the thirty-mile/sixty-minute access standard, the employee is generally required to select from MPN specialists, though the three-physician minimum ensures meaningful choice.

Second and Third Opinions

An injured worker's right to second and third opinions within an MPN is established by Labor Code Section 4616.3(c): "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." The regulation does not require a specific articulated disagreement with the treating physician's clinical judgment; in the recent decision In re Williamson v. Claims Administrator, the WCAB clarified that "an applicant's failure to articulate a specific objection to the treating physician's diagnosis and treatment recommendations did not preclude him from obtaining a second opinion consultation."

The second opinion process is detailed in CCR Section 9767.7. The employee's responsibility is to: (1) notify the employer or claims administrator of the dispute in writing or orally; (2) select a physician from a list of available MPN providers provided by the employer; and (3) make an appointment within sixty days of receiving the provider list. The employer's responsibility includes providing "at least a regional area listing of MPN providers and/or specialists" appropriate to the dispute, informing the employee of the right to request medical records, and notifying the second opinion physician of the nature of the dispute. If the employee fails

to schedule the appointment within sixty days, the right to the second opinion is deemed waived with respect to that particular dispute.

The second opinion physician renders a written opinion addressing the disputed diagnosis or treatment and may recommend alternative approaches. If the second opinion physician determines that the case is outside their scope of practice, the employer must provide a new list of available physicians for the employee to select from. Importantly, the second opinion consultation does not require utilization review or pre-authorization; it is a statutory right that may be invoked independent of whether the treating physician's recommendation has been authorized.

If the employee disputes the second opinion physician's findings, a third opinion can be pursued using the identical process. If the employee disputes the third opinion, the final step is to request an MPN Independent Medical Review (MPN-IMR) under Labor Code Section 4616.4 and CCR SectionSection 9768.1-9768.9. The MPN-IMR process differs from the standard utilization review IMR process; it is specific to disputes arising within MPN contexts and involves selection of an independent medical reviewer from a specialized panel, with consideration of the employee's preference for geographic proximity (within thirty miles, with increasing search radiuses if necessary).

Coverage for Physical Injuries and Occupational Illnesses

Acute Occupational Injuries and the Role of MPNs

California workers' compensation law recognizes occupational injuries as any injury arising out of and occurring in the course of employment, whether acute or cumulative. For acute injuries-a hand laceration from equipment, a back strain from lifting, a leg fracture from a fall-the MPN serves as the gateway to medical care. Once an employer establishes an approved MPN, injured workers with acute injuries are required to receive treatment through the MPN unless they have pre-designated a personal physician or fall within another statutory exception.

The types of acute injuries most commonly managed through MPNs include traumatic orthopedic injuries (fractures, dislocations, ligament tears), crush injuries, burn injuries, occupational lacerations, and acute neurological trauma. The MPN's composition must reflect these common injuries through availability of orthopedic surgeons, emergency physicians, and other trauma specialists. In construction, agriculture, and manufacturing settings, the MPN typically includes more extensive orthopedic resources than in office-based industries.

The treatment pathway for an acute injury within an MPN begins at the first medical visit to an MPN-approved emergency room, urgent care facility, or primary care physician. The provider documents the injury, performs initial examinations and imaging, and initiates treatment. If hospitalization is required, the MPN's emergency care exception (CCR Section 9767.5(j)) permits treatment at any hospital without MPN restriction, though subsequent inpatient care falls back under MPN governance. Once the acute phase stabilizes and the worker enters recovery and rehabilitation, the MPN framework regulates ongoing care, specialist consultations, and authorization of advanced imaging, surgical procedures, and ancillary services.

Occupational Diseases and Cumulative Trauma Conditions

Occupational diseases-conditions resulting from repeated exposure to workplace hazards rather than a single accident-are addressed under Labor Code Section 5307.1 (currently Section 5307) and create different evidentiary requirements than acute injuries, but operate within the same MPN framework once the disease is accepted as compensable. Cumulative trauma conditions, such as carpal tunnel syndrome from repetitive keyboarding, epicondylitis from repetitive gripping, or lower back strain from sustained heavy lifting, represent the majority of occupational disease claims in many industries.

The treatment of occupational diseases within MPNs requires specialists trained in occupational medicine. An injured worker with work-related carpal tunnel syndrome, for example, would typically require evaluation by an occupational medicine physician or hand surgery specialist who understands the relationship between workplace activities and the condition. The MPN's requirement to include "providers of occupational health services and specialists who can treat common injuries experienced by the covered injured employees based on the type of occupation or industry in which the employee is engaged" directly addresses these cumulative trauma cases.

An important nuance appears in the Murillo decision regarding specialist selection in occupational disease cases. An employee with a work-related condition requiring specialist care must demonstrate, if challenged,

that the specialist is treating a condition arising from the occupational injury. The specialist access standard (thirty miles/sixty minutes) applies, not the more restrictive primary care standard, but the MPN must include specialists treating the relevant medical condition.

Ancillary Services and Non-Physician Provider Coverage

Beyond physician-provided care, MPNs must address ancillary services-diagnostic imaging, physical therapy, occupational therapy, durable medical equipment (DME), home health care, and other non-physician services. CCR Section 9767.5(d) addresses ancillary service availability: "If an MPN provides ancillary services and those services or goods are not available within a reasonable time or a reasonable geographic area to a covered employee, then the employee may obtain necessary ancillary services outside of the MPN within a reasonable geographic area." This provision permits MPNs to provide comprehensive services, including ancillary care, without imposing the same strict access standards that govern physician services.

Historically, California workers' compensation law has permitted a broad range of allied health professionals to provide compensable treatment. Chiropractors and acupuncturists are specifically addressed in the MPN regulations. CCR Section 9767.1 requires that "MPNs must include acupuncturists and chiropractors as providers if they are commonly used by the employees being treated." This industry-specific requirement reflects recognition that certain occupations rely extensively on chiropractic care for musculoskeletal conditions. Conversely, an MPN serving office workers might justify limited chiropractic resources if the employee population has low utilization of such services.

Ancillary care represents a substantial portion of workers' compensation medical costs-estimated at approximately thirty percent of total medical spend across the industry. The major categories include physical therapy (PT) and occupational therapy (OT), which address functional recovery and return-to-work outcomes; diagnostic imaging (X-ray, MRI, CT, ultrasound), which guides treatment decisions; durable medical equipment and supplies (braces, orthotics, crutches); home health services for immobilized or severely disabled workers; and vocational rehabilitation services. These services are essential to achieving the workers' compensation system's dual goals of adequate medical care and timely return to work.

Coordination of ancillary services within MPNs is managed through the network's structure. Some MPNs subcontract with specialized ancillary care networks (such as CorVel's ancillary care solutions or similar third-party arrangements), while others directly credential ancillary providers within their physician network. The regulation permits this flexibility so long as the services meet the availability and access standards. An injured worker whose PT provider must delay an appointment beyond reasonable timeframes may access PT outside the MPN, with the costs remaining the employer's responsibility.

Coverage for Non-Physical and Psychological Occupational Injuries

Legal Recognition of Occupational Illnesses and Stress-Related Claims

California law explicitly recognizes occupational illnesses resulting from non-physical workplace stressors, though proof requirements are more stringent than for physical injuries. Labor Code Section 3208.3 establishes that injury from stress is compensable "if the employee proves by clear and convincing evidence that the employee sustained an occupational disease or injury caused by stress occurring in the performance of a duty of the employment." The statute also requires that "the employment by the employer is the predominant cause of the injury or illness." This "predominant cause" and "clear and convincing evidence" standard creates a higher bar than for physical injuries, where causation can often be established through temporal proximity to the work event.

The types of workplace stress-related injuries recognized in case law include anxiety disorders, depressive disorders, post-traumatic stress disorder (PTSD), and adjustment disorders arising from occupational circumstances. Classic scenarios include first responders (police officers, firefighters, paramedics) exposed to critical incidents or traumatic events in the course of duty; healthcare workers experiencing cumulative exposure to patient trauma or critical care situations; employees subjected to ongoing harassment, discrimination, or unlawful personnel actions; and employees facing sudden job loss or significant adverse employment actions.

An important distinction exists between physical injury producing psychological consequences (which requires showing that the physical injury caused the psychiatric symptoms) and pure psychological injury (which requires showing that workplace stressors caused the injury independent of any physical trauma). A construction worker who sustains a workplace injury, undergoes surgery, experiences chronic pain, and

develops depression from the chronic pain condition faces a different evidentiary pathway than a worker alleging that workplace stress management practices caused depression absent physical injury.

MPN Coverage and Treatment of Psychological Injuries

The California workers' compensation system has progressively expanded acceptance of psychological injury claims, and MPNs must accommodate treatment of these conditions. The MPN's provider requirements address psychological care through inclusion of psychiatrists and psychologists. CCR Section 9767.1 specifies that licensed providers are to be included in the MPN, and the statute lists "psychologists" as eligible providers, alongside physicians, surgeons, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners. Additionally, MPNs may include "ancillary service providers such as physical therapists," but the focus on psychological treatment is on the primary provider-the psychiatrist or psychologist who provides evaluations and ongoing therapy.

Treatment authorization for psychological injuries within an MPN requires that the injury meet the statutory definition of occupational disease or injury under Labor Code Section 5307 (for conditions arising from repeated stressors) or Section 3208.3 (for injury caused by stress). Once accepted as compensable, the injured worker accesses psychological treatment through the MPN in the same manner as physical injury treatment. The claims administrator provides a list of MPN psychiatrists or psychologists, the employee selects a provider, and treatment proceeds subject to utilization review of proposed interventions.

The MPN's access standards apply to psychological care provision: the employee must be able to access a psychiatrist or psychologist within the applicable geographic and timing standards. For primary mental health treatment, the fifteen-mile/thirty-minute standard applies; for specialty psychological services (such as trauma-focused cognitive behavioral therapy or other evidence-based treatments for PTSD), the thirty-mile/sixty-minute specialist standard applies. These distance requirements are particularly significant for psychological injury cases, as the availability of trauma-informed providers who specialize in occupational PTSD may be limited in certain geographic areas.

Integrated Physical-Psychological Treatment and Cumulative Harm Models

Many workers' compensation injuries involve both physical and psychological components. A worker with a chronic pain condition may develop anxiety or depression directly resulting from the chronic pain, the functional limitations it imposes, or the extended treatment course itself. The MPN must accommodate treatment of both components simultaneously, which requires coordination between the physician managing pain (typically orthopedic surgeon, pain management specialist, or physiatrist) and the psychologist or psychiatrist addressing psychological sequelae.

Cumulative trauma cases involving occupational disease frequently produce psychological components. A worker with decades of repetitive occupational stress-such as a teacher facing escalating classroom discipline challenges, a nurse experiencing repeated exposure to critical care situations, or a corrections officer subjected to chronic workplace violence exposure-may develop recognized psychiatric conditions. The predominant cause requirement under Section 3208.3 requires clear evidence that the workplace stress was the predominant cause, not pre-existing mental health vulnerabilities or non-work stressors.

Quality of Mental Health Evaluation and Expert Witness Requirements

For disputed psychological injury claims, the MPN framework incorporates qualified medical evaluator (QME) evaluations and, when applicable, agreed medical evaluator (AME) assessments. The evaluating physician (either QME or AME) must be licensed as a medical doctor (M.D.) or doctor of osteopathic medicine (D.O.), not a psychologist, though psychiatrists may serve as QME/AME. Psychologists may provide medical-legal opinions supporting workers' compensation claims through specialized evaluation protocols, often coordinated with the QME process, but the formal medical determination role is reserved to licensed physicians.

For injured workers seeking to maximize their psychological injury claim, expert psychological testimony is often essential. California case law has established that psychologists, social workers, and counselors can provide credible evidence supporting psychiatric diagnoses and causation. The evaluation should address the worker's functional impairment (using standardized instruments such as the Global Assessment of Functioning scale), the temporal relationship between workplace stressors and symptom onset, alternative causative factors, and specific workplace events or conditions that caused distress.

Types of Medical Providers and Treatment Modalities within MPNs

Physician Specialties Required by Industry and Injury Type

The MPN regulations require that MPNs include an "adequate number and type of physicians" appropriate to the industry and types of injuries expected. This requirement compels MPN applicants to analyze their covered employee population and design networks accordingly. An MPN serving construction workers, for example, must include orthopedic surgeons, trauma surgeons, hand surgeons, and occupational medicine physicians. An MPN serving office workers might justify different specialty composition, potentially with greater emphasis on occupational medicine, ergonomics specialists, and psychological healthcare.

The primary care physicians in an MPN typically include internists, family practitioners, and occupational medicine physicians. These providers serve as gatekeepers for the system, conducting initial evaluations, ordering diagnostic testing, and determining when specialist consultation is needed. The requirement for three available primary care physicians within fifteen miles/thirty minutes ensures that injured workers have choice among primary providers and are not dependent on a single clinician.

Beyond primary care, the major specialty disciplines represented in most MPNs include orthopedic surgery (addressing fractures, joint injuries, and musculoskeletal trauma), general surgery (for lacerations, crush injuries, and other trauma requiring surgical intervention), neurosurgery (for spinal cord injuries and traumatic brain injuries), urology (for occupational injuries to genitourinary systems), ophthalmology (for ocular trauma and chemical eye injuries), otolaryngology (for head and neck trauma), psychiatry and psychology (for psychological injuries and stress-related conditions), physical medicine and rehabilitation/physiatry (for functional recovery and pain management), and pain management specialists (including anesthesiologists with pain management credentials).

Licensed Professional Status and Scope of Practice

The statutory framework permits MPNs to include providers beyond physicians. California Labor Code Section 4616(a)(1) specifies that the MPN "shall include physicians," but CCR Section 9767.1 permits inclusion of "Licensed physicians and providers of medical services," which include "physicians, surgeons, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners." Each of these provider categories has defined scope of practice under California law.

Psychologists in California must be licensed by the Board of Psychology and hold a doctoral degree (Ph.D. or Psy.D.). Within workers' compensation, psychologists may provide psychological evaluation, testing, and therapy for occupational injuries and illnesses. However, psychologists cannot prescribe medications (except limited prescriptions in certain cases under California law), which creates a gap for injured workers who require both psychological counseling and pharmacological treatment for psychiatric conditions. This gap is typically addressed by referral to a psychiatrist (who is an M.D. with psychiatric specialization and can prescribe medications) for medication management while the psychologist continues psychotherapy.

Acupuncturists must be licensed by the California Acupuncture Board and, since 2020, must hold either a Master's degree in acupuncture or have completed a minimum of 3,000 hours of training. Within workers' compensation, acupuncture is an approved treatment modality for certain conditions, particularly musculoskeletal pain and occupational illnesses. The MPN must include acupuncturists if they are "commonly used by the employees being treated," creating an obligation to include acupuncture in networks serving populations likely to utilize this treatment.

Chiropractors must be licensed by the State Board of Chiropractic Examiners and hold a Doctor of Chiropractic (D.C.) degree. Workers' compensation law permits chiropractic treatment for musculoskeletal occupational injuries, with certain limitations (such as the restriction that a chiropractor cannot be an employee's personal physician after the employee has received twenty-four chiropractic visits, unless the physician holds specific qualifications). MPNs serving manual labor industries typically include chiropractors as part of the musculoskeletal treatment team.

Podiatrists must be licensed by the Board of Podiatric Medicine and hold a Doctor of Podiatric Medicine (D.P.M.) degree. They are included in MPNs when foot and ankle injuries are anticipated-relevant for workers in occupations involving standing, climbing, or repetitive foot stressors.

Optometrists, holding a Doctor of Optometry (O.D.) degree and licensed by the Board of Optometry, are included to address visual injuries from occupational hazards such as chemical exposure, foreign body injuries, or trauma.

Ancillary Service Providers and Physical Rehabilitation Specialists

In addition to primary and specialty physicians, MPNs include extensive networks of ancillary service providers. Physical therapists (PT) and occupational therapists (OT), licensed by the Physical Therapy Board and Occupational Therapy Board respectively, are essential to the MPN's rehabilitation mission. These professionals typically hold Master's degrees (increasingly, Doctor of Physical Therapy degrees) and provide evidence-based functional rehabilitation aimed at restoring worker capacity and facilitating return to work.

Durable medical equipment (DME) suppliers provide mobility aids, braces, orthotic devices, and medical equipment necessary for patient care. These vendors are typically credentialed through the MPN and must maintain quality standards and appropriate pricing to ensure that DME costs do not become excessive relative to clinical benefit.

Home health agencies provide skilled nursing care, physical therapy, occupational therapy, and other services to injured workers unable to travel for outpatient care. These services are particularly important for workers with mobility limitations or those in rural areas distant from clinical facilities.

Diagnostic service providers-imaging centers, laboratory facilities, electromyography (EMG) testing centers-are credentialed within MPNs to ensure availability of diagnostic testing needed to guide treatment decisions. The MPN's role in coordinating diagnostic services helps avoid unnecessary or redundant testing while ensuring that clinically indicated imaging and laboratory studies are accessible.

Treatment Modalities and Medical Necessity Standards

The scope of treatments available through MPNs is governed by two standards: the Medical Treatment Utilization Schedule (MTUS) established pursuant to Labor Code Section 5307.27, and, where MTUS is silent or inapplicable, the American College of Occupational Medicine (ACOM) Occupational Medicine Practice Guidelines. These treatment guidelines establish which interventions are considered appropriate for specific conditions, what duration of treatment is anticipated, and when continuation of treatment requires justification through utilization review.

For orthopedic injuries, the MTUS and ACOM guidelines address non-surgical interventions (rest, ice, anti-inflammatory medications, physical therapy, injections), surgical decision points, and rehabilitation protocols. Treatment typically progresses through conservative management before advancing to surgical intervention, though acutely unstable injuries may require surgery earlier in the course.

For pain management, guidelines address appropriate use of analgesic medications, interventional pain procedures (joint injections, nerve blocks, spinal cord stimulation), and psychological approaches to pain. The opioid crisis has prompted restrictions on long-term opioid prescribing in workers' compensation, with guidelines now emphasizing multimodal pain management and functional restoration.

For occupational diseases and cumulative trauma conditions, treatment protocols address ergonomic modifications, activity modification, therapeutic interventions, and surgical options when conservative approaches fail. The evidence-based guidelines tend to be more conservative for occupational diseases than for acute injuries, reflecting recognition that these conditions often have prolonged courses requiring extended treatment.

For psychological injuries, treatment protocols address psychotherapy modalities (cognitive-behavioral therapy, trauma-focused therapy, acceptance and commitment therapy), psychotropic medications, and rehabilitation aimed at restoring functional capacity and return to work. The MTUS and ACOM guidelines for psychological injury are less prescriptive than for physical injuries, reflecting the individualized nature of mental health treatment.

Medical Provider Networks by Insurance Carrier and Structural Variations

Major Insurance Carriers and Custom MPN Designs

California's workers' compensation market includes multiple insurance carriers operating approved MPNs. As of February 2026, the Division of Workers' Compensation's active MPN list identifies over 2,400 individual MPNs across the state. However, the vast majority are inactive, suspended, or terminated, leaving approximately 194 actively maintained MPNs managed by actual employers and insurers. The most prominent carriers with substantial Northern California presence include State Fund California (the state compensation insurance fund), Hartford Fire Insurance Company, CorVel, Coventry Health Care, PMA Companies, and numerous regional and specialty carriers.

Each major carrier structures its MPN differently based on its underwriting philosophy, client base, and geographic footprint. State Fund California, as the state-operated carrier serving employers without private insurance, maintains a geographically comprehensive MPN covering all California regions with integrated occupational medicine services. Private carriers often differentiate their MPN offerings by industry specialization. Hartford's MPN includes specialized networks for construction, healthcare, manufacturing, and other high-hazard industries. Carriers specializing in professional liability or high-income professionals may offer smaller, more selective networks emphasizing musculoskeletal care and psychological services.

Third-Party Administration and MPN Vendor Relationships

The regulatory landscape permits "entities providing physician network services" to establish MPNs on behalf of insurers or employers. In practice, this has created complex vendor relationships. Major third-party administrators (TPAs) like Sedgwick, Broadspire, and others often subcontract with specialized MPN vendors to manage network operations. A single insurance carrier might utilize different MPN vendors in different regions or for different client groups, creating confusion regarding the applicable MPN, the correct contact information for the medical access assistant, and the actual provider directory.

This layered structure has generated significant problems for injured workers. In some documented cases, the employer's initial injury notice form identifies an MPN and contact information, but that information is inaccurate or leads to a vendor that no longer manages that MPN. Injured workers and their representatives must navigate a confusing landscape to identify the correct MPN entity, locate functioning provider directories, and reach the MAA. This navigation problem affects both the initial identification of available providers and subsequent disputes over whether the MPN meets access standards.

Geocoding Requirements and Access Standard Compliance Documentation

Beginning with regulatory amendments effective in 2014, the DWC implemented a geocoding requirement for MPN applications and reapprovals. MPNs seeking approval must now submit electronic geocoding results demonstrating that their provider networks meet access standards on a location-specific basis. The required geocoding submissions include separate Excel files showing: (1) a complete list of zip codes in the MPN's service area; (2) analysis of whether at least three primary treating physicians are available within the fifteen-mile standard from the center of each zip code; (3) analysis of hospital and emergency care provider locations; (4) analysis of specialist availability; and (5) identification of any zip codes where access standards are not met.

This geocoding requirement theoretically creates accountability for MPN compliance with access standards. An MPN cannot claim to meet standards through general assertions about provider availability; it must provide granular geographic data demonstrating that access requirements are met at specific locations. However, the data is only as accurate as the provider information submitted, and as discussed below, many MPNs maintain outdated provider directories that include inactive or deceased physicians.

Electronic Directories and Provider Verification Systems

MPNs are required to maintain provider directories accessible to covered employees. The regulation requires that MPNs provide "a printed directory or an electronic directory available to each covered employee upon request, giving the names, addresses, telephone numbers and specialties of all available MPN physicians and other providers available to treat covered employees." Additionally, the directory "shall include the name and address of each hospital or emergency health care facility in the MPN" and information about how injured workers can access the medical access assistant.

In practice, MPN provider directories exist in multiple formats: printed directories mailed to employers, PDF directories on the MPN's website, searchable databases accessible through the MPN vendor's portal, and electronic listings available through third-party platforms. The quality and currency of these directories vary dramatically. Some carriers maintain real-time updated directories; others operate with outdated provider lists that include physicians who no longer participate in the MPN or who have retired from practice.

The problem is compounded by the vendor relationships described above. An injured worker seeking to access the State Fund MPN provider directory may visit the State Fund website and locate a directory; the same worker's employer may receive a different directory from a third-party administrator; and the claims adjuster managing the case may reference yet another directory maintained by a TPA's MPN management vendor. These multiple versions of the "official" directory frequently contain discrepancies.

Regional and Industry-Specific Network Variations

MPNs often vary by geographic region and industry served. The DWC's active MPN list shows significant concentration of approved networks in urban areas-particularly the Bay Area, greater Los Angeles, and the Central Valley-while more sparse network options exist in rural regions. Some MPNs operate statewide; others are limited to specific regions or counties.

Industry-specific MPNs include networks designed for construction, agriculture, transportation, healthcare, and other high-risk sectors. A construction MPN might include more orthopedic surgeons, occupational medicine physicians, and occupational health specialists compared to a network serving administrative workers. The flexibility in network design, while supporting industry-specific medical management, also creates complexity for injured workers unfamiliar with their employer's industry classification within the MPN framework.

Dispute Resolution Mechanisms and Independent Medical Review Processes

Utilization Review and Initial Dispute Resolution

When an injured worker's treating physician recommends medical treatment, the claims administrator conducts utilization review (UR) to determine whether the treatment meets medical necessity standards under applicable treatment guidelines. Utilization review is distinct from MPN membership review; a treating provider can be authorized to provide treatment even if not an MPN member, and conversely, MPN membership does not guarantee authorization of all treatments proposed.

If the claims administrator denies or modifies the treatment authorization through UR, the injured worker and treating physician receive an Explanation of Review (EOR) detailing the denial rationale and referencing the guidelines applied. Within thirty days of receiving the UR denial, the worker may request an Independent Medical Review (UR-IMR) under Labor Code Section 4610.6. This UR-IMR process is distinct from the MPN-specific independent medical review (MPN-IMR) discussed below.

The UR-IMR process involves submission of an application to Maximus (contracted by the state to administer UR-IMRs), assignment of an IMR physician from a panel of licensed physicians certified in the relevant specialty, and the IMR physician's decision within thirty days of receiving all relevant medical documents. The IMR physician must follow medical treatment guidelines and render a decision addressing whether the disputed treatment is medically necessary. If the IMR physician agrees that treatment is necessary, the claims administrator must authorize the treatment within five business days.

Second and Third Opinion Process Within the MPN

The MPN-specific dispute resolution begins with the second opinion process described earlier under CCR Section 9767.7. An injured worker who disputes the treating physician's diagnosis or treatment may request a second opinion from another MPN physician. This second opinion right is statutory and does not require that a UR denial first occur; an injured worker may invoke the right proactively without waiting for an authorization decision.

The process requires that the employer provide a list of at least three available MPN physicians or specialists appropriate to the dispute. The employee selects one, notifies the employer of the appointment date, and the second opinion proceeds. The second opinion physician renders a written opinion within twenty days of the appointment, addressing the disputed diagnosis or treatment and proposing alternative approaches if appropriate.

If the employee disputes the second opinion, a third opinion can be pursued using identical procedures. The third opinion physician again provides written findings and alternative recommendations. Notably, the regulations do not permit a fourth or subsequent opinion; once the third opinion is issued, the dispute resolution pathway within the MPN framework is exhausted (unless the employee chooses to pursue UR-IMR instead).

MPN Independent Medical Review (MPN-IMR)

If the employee disputes the third opinion physician's findings, the next step is MPN Independent Medical Review under Labor Code Section 4616.4 and CCR SectionSection 9768.1-9768.9. The MPN-IMR is a distinct process from UR-IMR, involving selection of an independent medical reviewer from a specialized panel, written notice to the employee of the reviewer's identity, and an opportunity for the employee to object based on conflicts of interest.

The administrative director's selection process prioritizes geographic proximity: "If the covered employee requests an in-person examination, the Administrative Director shall randomly select a physician from the panel of available Independent Medical Reviewers, with an appropriate specialty, who has an office located within thirty miles of the employee's residence address, to be the Independent Medical Reviewer." If only one qualified physician is within thirty miles, that physician is selected. If none exist within thirty miles, the search expands in five-mile increments until a physician is located.

Once assigned, the MPN-IMR physician has up to thirty days to schedule an in-person examination (if requested by the employee) or will conduct a record review (if the employee requests review-only). The employee may contact the IMR to request an appointment, and has sixty days from receiving the IMR's name to schedule the exam; failure to schedule within sixty days waives the MPN-IMR right. The IMR's decision is issued to the employee, treating physician, MPN contact, and claims administrator, and addresses whether the disputed diagnosis or treatment is appropriate based on medical necessity standards.

Interaction Between MPN Dispute Procedures and Utilization Review

A practical question arises regarding the interaction between MPN-specific dispute resolution (second/third opinion and MPN-IMR) and the general utilization review/UR-IMR process. The regulations and case law clarify that these are parallel, not sequential, processes. An injured worker may pursue second and third opinions within the MPN independently of whether a UR denial has been issued. Conversely, if a treatment recommendation has been denied through UR, the worker may seek UR-IMR without exhausting the MPN second/third opinion process.

However, practical sequencing considerations suggest that many injured workers initially attempt MPN second and third opinions before resorting to UR-IMR, since the MPN process permits the worker to select providers personally and may be faster. Alternatively, an injured worker might pursue UR-IMR if the claims administrator has already denied authorization, as the UR-IMR process directly addresses medical necessity. The choice between processes involves strategic considerations: the MPN process emphasizes clinical opinion comparison, while UR-IMR emphasizes explicit application of treatment guidelines.

Continuity of Care and Transfer of Injured Workers Into MPNs

Treatment Completion for Pre-MPN Injuries

An important protection exists for injured workers whose injuries occurred before the MPN coverage became effective or before the employer's MPN was implemented. Labor Code Section 4616.2 and CCR Section 9767.9 address the situation where a treating provider is not a member of the newly implemented MPN. In such cases, the employer may be required to permit treatment completion with the existing provider under specific circumstances.

CCR Section 9767.9(e) specifies the conditions under which completion of treatment with a non-MPN provider is authorized: (1) a serious chronic condition as defined by CCR Section 9767.9(e)(2)-a medical condition persisting beyond ninety days requiring ongoing treatment; (2) a terminal illness as defined by CCR Section 9767.9(e)(3); (3) performance of a surgery or procedure authorized and documented as part of the employee's treatment course, to occur within 180 days of the MPN effective date; or (4) transfer of a previously injured employee into a newly implemented MPN where the injury does not meet the chronic condition or terminal illness definitions.

For serious chronic conditions, completion of treatment is authorized for a period up to one year "to complete a course of treatment approved by the employer or insurer" and "to arrange for transfer to another provider within the MPN, as determined by the insurer, employer, or entity that provides physician network services." This recognition of serious chronic conditions protects injured workers engaged in long-term treatment (such as for chronic pain conditions, serious orthopedic injuries, or complex psychological conditions) from abrupt discontinuation of care.

The process requires that the employer or claims administrator provide written notice in English and Spanish to the injured worker, explaining the medical determination regarding whether the condition meets the continuity of care exception. If the injured worker disputes the determination-claiming that their condition is actually a serious chronic condition contrary to the employer's position-the dispute is resolved under Labor Code Section 4062 (medical dispute procedures), not through the MPN dispute mechanisms.

Continuity of Care Policy Requirements

Every MPN must include a written continuity of care policy addressing how the network will handle situations where providers are terminated or no longer available. The policy must address the circumstances under which injured workers may continue treatment with a terminated provider and the process for arranging safe transitions to continuing providers within the network.

The PRISM MPN's continuity of care policy, included in the research sources, exemplifies the regulatory requirements. It specifies that completion of treatment with a terminated provider is authorized for serious chronic conditions (up to twelve months), terminal illnesses (for the duration), and authorized surgeries within 180 days of contract termination. Additionally, the policy addresses compensation for terminated providers continuing to treat: they must be compensated at rates comparable to actively contracting providers in the same geographic area, "unless otherwise agreed by the terminated provider and the employer or its claims administrator."

If the provider is terminated for cause (disciplinary action, fraud, or criminal activity), the continuity of care protections do not apply, and the injured worker must transition immediately to a continuing network provider. This carve-out reflects the principle that injured workers should not be compelled to continue treatment with providers subject to disciplinary actions.

Challenges, Limitations, and Practical Implementation Barriers

Documented Problems with Provider Directory Accuracy and Accessibility

Despite regulatory requirements for provider directories, multiple sources document serious deficiencies in directory accuracy and accessibility. One detailed case study describes an attempt to locate an eligible MPN provider through multiple channels: accessing the state's official MPN list, navigating to the listed MPN website, finding only generic landing pages, attempting to access provider directories, encountering non-functional search functions, and ultimately being unable to reach a functioning Medical Access Assistant despite repeated attempts. The case study identifies a pattern where the claims administrator, the insurer, the MPN entity, and various third-party vendors each maintain different versions of the provider directory or contact information, creating frustration and preventing injured workers from locating care.

Another documented problem involves provider directories that include physicians no longer in active practice. Geocoding submissions may reference physicians who have retired, moved to other states, or deceased, artificially inflating the apparent availability of providers in a given geographic area. The DWC's current system for monitoring provider currency is insufficient to prevent these inaccuracies.

The problem is compounded by vendor layering. An injured worker insured by Insurer A, whose workers' compensation policy is administered by TPA B, whose MPN is managed by MPN Vendor C, receives information about the MPN from the insurer (which may reference outdated contact information) and the employer (which may reference different information). The injured worker calling the listed MAA phone number reaches a general administrative line that cannot specifically address MPN provider availability.

Enforcement and Compliance Monitoring by the DWC

The DWC's ability to monitor and enforce MPN compliance has historically been limited. The agency is understaffed relative to the volume of approved networks and the complexity of access standard verification. While the geocoding requirement represents a significant step toward accountability, the accuracy of geocoding submissions depends on the timeliness and accuracy of provider rosters submitted by MPNs-a dependency that assumes good faith compliance.

The agency has limited formal enforcement tools beyond denial of MPN renewal. An MPN found to violate access standards could theoretically have its approval suspended or terminated, but such actions are rare. Instead, complaints about MPN access failures are typically addressed through individual disputes between injured workers and claims administrators, with the injured worker bearing the burden of documenting access failure and pursuing formal remedies.

Recent regulatory amendments, proposed in February 2025, suggest recognition of these problems. The DWC has indicated intention to invite stakeholder comment on proposed updates to MPN regulations and rules for medical treatment billing, suggesting potential revisions to address documented compliance issues.

Geographic Disparities and Rural Access Barriers

Rural areas throughout California face systematic MPN access challenges. Many rural counties have fewer than ten approved, active MPNs, and those networks may have limited specialist availability or extended wait

times exceeding regulatory standards. Alternative access standards proposed by MPNs serving rural regions attempt to address these realities, but injured workers in areas where alternative standards have not been approved may find themselves unable to access required care within standard timeframes.

The Northern California region includes significant rural areas-particularly the Sierra Nevada foothills, the far north coast, and inland regions-where MPN provider availability remains a practical barrier to access. Some rural MPNs have successfully proposed and implemented alternative standards that accommodate the geographic realities of sparse physician distribution. However, injured workers in regions where alternative standards have not been implemented may be legally required to travel extended distances to access MPN-required care.

Discrepancies Between MPN Membership and Authorization Status

A documented problem involves claims administrators denying payment for treatment provided by physicians claimed to be outside the MPN, even when the MPN in question does not exist, is not currently approved, or does not include the provider in question. In one documented case, a claims administrator authorized treatment through UR, then denied payment claiming the provider was not in the applicable MPN-despite the DWC's records showing that the MPN applicant (the insurer) had no approved MPN at all.

This pattern suggests confusion (or occasionally deliberate misrepresentation) regarding the relationship between MPN membership and treatment authorization. Utilization review and MPN membership are theoretically independent determinations: a treatment can be authorized through UR regardless of provider MPN status, and conversely, MPN membership provides no assurance of authorization. However, in practice, some claims administrators use MPN non-membership as a secondary basis for payment denial, creating confusion for providers.

Time and Resource Requirements for Dispute Resolution

The multiple dispute processes available to injured workers-second and third opinions within the MPN, MPN-IMR, UR-IMR, and ultimately medical-legal evaluation under Labor Code SectionSection 4061-4062-require time and administrative effort. An injured worker contesting a treating physician's recommendation might spend months navigating second and third opinions, waiting for MPN-IMR assignment and scheduling, and then pursuing additional disputes through utilization review or medical-legal processes. During this period, the injured worker may be denied access to the disputed treatment, potentially delaying recovery.

The sixty-day timeframes for scheduling second and third opinion appointments and MPN-IMR examinations can pass quickly, particularly if the employee does not actively track deadlines or if the MPN or MAA provides inaccurate timeframe information. Failure to meet these deadlines results in waiver of the specific dispute mechanism, leaving the employee with limited remedies.

Conclusion and Practical Recommendations for Navigating the MPN System

Summary of Key Findings

California's workers' compensation Medical Provider Network system represents a significant but imperfect mechanism for managing occupational medical care. The statutory and regulatory framework, grounded in Labor Code Section 4616 and implementing regulations in CCR SectionSection 9767.1-9767.19, creates mandatory access standards that theoretically ensure injured workers receive timely care from adequately diverse provider networks. The access standards-three available primary care physicians within fifteen miles or thirty minutes, specialists within thirty miles or sixty minutes, first appointment availability within three business days, specialist appointment availability within twenty business days-establish measurable benchmarks for adequacy.

In practice, the system operates unevenly across different geographic regions, injury types, and carrier implementations. Urban areas with concentrated populations generally meet access standards; rural areas face systematic shortfalls. Common occupational injuries (orthopedic, occupational medicine) have adequate provider networks; subspecialties may require patients to travel or pursue external treatment. Large carriers with substantial California footprints maintain relatively current provider directories and functional MAA services; smaller carriers and third-party vendors struggle with directory accuracy and accessibility.

The dispute resolution mechanisms-second and third opinions within the MPN, MPN-IMR, and UR-IMR-provide injured workers with formal pathways to challenge denial or inappropriate restriction of treatment. However, these processes require time, documentation, and persistence. The burden falls substantially on

injured workers and their representatives to navigate the system, verify provider availability, and initiate formal disputes when access barriers emerge.

Coverage for both physical occupational injuries and non-physical injuries (psychological conditions, occupational diseases) is legally mandated and typically available within MPNs, though specialized providers for occupational stress-related conditions may be limited in certain areas. The integration of ancillary services-physical therapy, occupational therapy, diagnostic imaging, durable medical equipment-within MPN structures supports functional recovery and return-to-work objectives, though access to these services can be restricted through MPN limitations.

Practical Recommendations for Injured Workers

Verify MPN Status Early: Upon sustaining a work injury, injured workers should confirm whether their employer has an approved MPN by contacting the employer, reviewing any workers' compensation notices provided, and if necessary, checking the DWC's active MPN list directly. Understanding the applicable MPN allows the worker to know what provider options are available and what dispute mechanisms are available if access barriers emerge.

Contact the Medical Access Assistant Directly: Rather than relying on employer-provided contact information or employer selection of providers, injured workers should proactively contact the MPN's Medical Access Assistant within the first few days after injury. Clearly explain the type of injury, request a list of at least three available providers, and ask about appointment availability. Document the date and time of the call, the name of the MAA representative (if provided), and the provider list or information received.

Document Everything: Maintain detailed records of all communications regarding provider selection, appointment scheduling, and access barriers. If the MAA cannot schedule an appointment within the legally required timeframes (three business days for primary care, twenty business days for specialist), document the specific dates of requests and the reasons provided for unavailability. This documentation becomes critical if the worker later needs to pursue formal dispute resolution or seek external provider care.

Pre-Designate a Personal Physician Before Injury: If employed and not covered by an MPN, or if working in a position where injury is possible, consider pre-designating a personal physician using DWC Form 9783. This must be completed and signed by both the employee and physician before any occupational injury occurs. If accomplished, the pre-designated physician becomes the treating provider regardless of MPN requirements.

Request Second and Third Opinions Proactively: If dissatisfied with a treating physician's diagnosis or proposed treatment, do not wait for a formal UR denial. Instead, invoke the statutory right to second and third opinions under Labor Code Section 4616.3. Notify the claims administrator in writing, request a list of at least three MPN physicians appropriate to the dispute, and select a physician for the second opinion. This process is faster than waiting for UR denial and subsequent UR-IMR.

Understand Your Specialist Rights: If referred to a specialist, confirm that the specialist is within MPN access standards (thirty miles/sixty minutes). If the MAA cannot schedule an appointment within ten business days, you have the right to obtain specialist care outside the MPN at the employer's expense. Exercise this right if necessary to obtain timely care.

Seek Legal Assistance for Complex Claims: For serious injuries requiring extended treatment, occupational disease claims requiring industry-specific medical management, or psychological injury claims requiring proof of causation, consider consulting with an experienced workers' compensation attorney or workers' compensation advocate. These professionals can navigate the dispute mechanisms, advocate for treatment access, and coordinate medical-legal evaluations supporting your claim.

Practical Recommendations for Employers and Claims Administrators

Maintain Current Provider Directories: Regularly verify that all physicians listed as MPN providers are active, appropriately credentialed, and willing to treat occupational injuries. Implement processes for removing retired or relocated physicians from directories within sixty days of departure. Provide updated directories to covered employees at least annually.

Ensure Medical Access Assistant Functionality: Verify that the MAA service is operational, that personnel assigned to MAA duties are properly trained on MPN procedures, and that MAA communications are documented and logged separately from claims administration duties. Implement call-tracking systems to

ensure that MAA calls are answered within reasonable timeframes and that employees receive accurate, current provider information.

Implement Geocoding Analysis: For MPNs approaching four-year reapproval deadlines, begin geocoding analysis early to identify any geographic areas where access standards are not met. Develop plans to either add providers to underserved areas or, if justified, propose alternative access standards with supporting documentation of health care shortage conditions.

Coordinate with Third-Party Vendors: If using third-party MPN vendors to manage network operations, establish clear accountability mechanisms. Require vendors to provide updated provider lists at specified intervals, to maintain functioning MAA services, and to track access standard compliance. Conduct periodic audits of vendor performance to verify that injured workers can actually locate and access care.

Communicate Clearly with Injured Workers: Provide clear, detailed information about MPN structure, MAA contact information, and the process for selecting providers. Ensure that initial injury notices include accurate, current information about how to access care. Offer Spanish-language materials and services reflecting the state's diverse workforce.

Practical Recommendations for Healthcare Providers

Verify MPN Status Before Treatment: Before treating an injured worker, confirm whether the patient is covered by an MPN and, if so, whether you are a participating provider. Obtain confirmation of MPN membership and current authorization procedures from the claims administrator. Clarify whether you will accept the MPN's fee schedule and whether the MPN's prior authorization procedures will be followed.

Participate in Provider Networks Strategically: For physicians considering MPN participation, evaluate the network's patient volume, fee schedule adequateness, prior authorization procedures, and dispute resolution mechanisms. MPNs offering below-market compensation or burdensome prior authorization procedures may not be worth the administrative overhead.

Document Access and Appointment Barriers: If injured workers contact your office requesting appointments but your schedule cannot accommodate them within regulatory timeframes, document the requests and scheduling barriers. If multiple injured workers are unable to access your care within required timeframes, this indicates that the MPN may be underestimating demand and may need provider expansion.

Future Regulatory Directions

The DWC's recent indication that it is considering regulatory updates to MPN requirements and medical treatment billing rules suggests potential future developments. Injured workers and employers should monitor proposed amendments for clarifications regarding access standard enforcement, provider directory accuracy, and MAA functionality. Participating in DWC stakeholder processes-through advocacy organizations, professional associations, or individual comments-can influence the direction of these regulatory refinements.

The fundamental tension underlying the MPN system-balancing employer cost containment against injured worker access and choice-will likely continue to generate regulatory and judicial attention. As the system evolves, the dual requirements of adequate access and meaningful provider choice should remain central to any regulatory modifications.

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California Workers' Compensation Medical Provider Networks: Legal Framework, Access Standards, and Practical Implementation

Executive Summary

Medical Provider Networks (MPNs) represent a foundational element of California's workers' compensation system, established under Labor Code Section 4616 and implementing regulations in California Code of Regulations Title 8, SectionSection 9767.1 through 9767.19.[1][2] As of February 2026, the state maintains approval for hundreds of active MPNs across multiple insurance carriers and self-insured employers, though the system has faced significant scrutiny regarding accessibility and enforceability of access standards.[3][4] An MPN functions as a curated network of physicians and medical providers established by either a workers' compensation insurer or self-insured employer, approved by the California Division of Workers' Compensation (DWC) administrative director, and designated to provide exclusive or prioritized medical treatment to injured workers employed by the sponsoring entity.[5] The legal framework mandates that MPNs maintain strict access standards-requiring at least three available primary treating physicians within fifteen miles or thirty minutes of an employee's residence or workplace, and specialists available within thirty miles or sixty minutes-while simultaneously providing injured workers with meaningful choice of providers after the initial appointment.[6][7] This system applies to both physical injuries sustained through acute workplace trauma and non-physical occupational injuries, including psychological conditions and cumulative trauma conditions recognized under Labor Code Section 3208.3.[8] The research presented herein addresses the operational structure of MPNs, the mechanisms by which injured workers locate and select treating physicians, the scope of medical providers and treatments available, and the variations across different insurance carriers operating in Northern California and nationwide.

Risk Assessment Summary: California injured workers face a mixed-risk landscape in navigating MPNs. High-confidence strengths include explicit statutory access standards, regulatory requirements for provider choice, and formal dispute resolution mechanisms through second and third opinion processes. Medium-confidence risks include documented difficulties in locating accurate MPN provider directories, inconsistent enforcement of access standards across different carriers, and practical barriers to accessing the medical access assistant service required by regulation.[9][10] The enforceability of MPN requirements depends substantially on whether an injured worker's specific MPN maintains current DWC approval status and complies with geocoding verification requirements.

Strategic Decision Framework: Injured workers and their representatives should approach MPN selection with the following considerations: first, verify that the applicable MPN maintains current DWC approval status by consulting the state's active MPN database; second, utilize the Medical Access Assistant (MAA) service as the primary mechanism for locating eligible providers rather than attempting to navigate opaque online directories; and third, document all communications with claims administrators regarding provider access, as such documentation becomes critical if disputes arise over whether the MPN meets applicable access standards. For employers and insurers, the framework requires consistent compliance with geocoding requirements upon reapproval, clear communication of MPN structure to covered employees, and maintenance of current provider listings to avoid denials of otherwise authorized treatment.

Timeline Considerations: Injured workers must understand several time-critical processes within the MPN framework. Non-emergency medical care must be available within three business days of notice to the MPN medical access assistant. Specialist appointments, when referred through the proper MPN process, must be available within twenty business days, or the employee may elect to seek treatment outside the network. Second and third opinion requests under Labor Code Section 4616.3 must be acted upon within specific timeframes, with appointments required within sixty days of receiving the provider list. These deadlines are enforceable and affect the worker's substantive rights.

Likelihood of Access: The qualitative assessment of whether an injured worker can obtain timely, appropriate medical treatment through an MPN varies by geographic location and injury type. For urban areas in Northern California with concentrated populations and multiple provider networks, the likelihood of meeting access standards is moderately high. For rural areas, particularly those designated as health care shortage zones, MPNs may propose alternative access standards, reducing confidence in standard fifteen-

mile or thirty-mile benchmarks. The availability of specialists for specific occupational injuries varies significantly by industry and specialty, with pain management, orthopedic surgery, and occupational medicine generally available across approved networks, while subspecialties may require patients to treat outside the MPN.

Legal Framework and Statutory Authority

Foundational Legislation and Regulatory Structure

The California workers' compensation system grants employers and insurers the authority to restrict injured workers' medical care to approved networks through a statutory framework enacted in 2003 and 2004. The primary legislative source is California Labor Code Section 4616, which 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." This statute represents a deliberate policy choice to allow cost management through provider selection while simultaneously imposing mandatory access and choice requirements to protect injured workers. The legislative intent balanced employer cost containment against employee rights to timely, appropriate medical care-a balance that continues to generate litigation and regulatory refinement more than two decades after implementation.

The statute explicitly requires that any MPN include a mixed provider base: at least twenty-five percent of physicians must specialize in non-occupational medicine, while the remainder focus on occupational injury treatment. This integration requirement reflects a recognition that work injuries often occur in patients with pre-existing conditions requiring concurrent management, and that occupational medicine specialists must operate within a broader clinical context. The network must also include "an adequate number and type of physicians" to treat common injuries based on "the type of occupation or industry in which the employee is engaged, and the geographic area where the employees are employed."[4] This industry-specific requirement means that an MPN serving construction workers may require different specialists than one serving office workers, and that geographic variations in available providers create legitimate differences in network composition across regions.

Labor Code Section 4616(c) includes a critical safeguard against perverse incentives: "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." This anti-steering provision reflects legislative concern that fee schedules or capitation arrangements might create incentives for providers to minimize care. Additionally, Section 4616(f) establishes that "No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, when these services are within the scope of the physician's practice, may modify, delay, or deny requests for authorization of medical treatment." This provision limits the ability of non-physician utilization review specialists to make medical decisions, though in practice the interaction between physician-directed utilization review and MPN membership requirements creates ongoing interpretive questions.

The regulatory implementing structure appears in California Code of Regulations Title 8, SectionSection 9767.1 through 9767.19. These regulations were initially adopted in 2004 and have been amended multiple times, most recently through 2018 updates that added geocoding requirements for demonstrating access standard compliance. The Administrative Director of the DWC holds primary authority to approve or deny MPN applications, though Labor Code Section 4616(b) includes a deemed approval mechanism: if the Administrative Director does not act on a submitted plan within sixty days, "it shall be deemed approved." In practice, most applications receive affirmative approval within the statutory period, though the Application for Reapproval process (required every four years) has generated documented delays.

Applicable Regulatory Requirements and Standards

The most operationally significant regulation is CCR Section 9767.5, which establishes the access standards that define whether an MPN provides adequate coverage to satisfy statutory requirements. These standards address geographic distance, travel time, appointment availability, and provider specialty requirements. The regulation mandates that an MPN must have "at least three available primary treating physicians 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." This "three available physicians" standard is not merely aspirational; it defines the minimum network size necessary for DWC approval and, as discussed below, its interpretation has generated significant case law.

For specialist care, CCR Section 9767.5(a)(2) requires that "an MPN must have providers of occupational health services and specialists who can treat common injuries experienced by the covered injured employees within 60 minutes or 30 miles of a covered employee's residence or workplace."[1] The regulation further specifies that "[a] MPN must have at least three available physicians of each specialty to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged." This language created interpretive questions-resolved in recent case law-about whether an injured worker requesting treatment from a specialist must demonstrate that three specialists in that specific field exist within the access standards, or whether the requirement applies only to "commonly used" specialties determined by the MPN applicant.

CCR Section 9767.5(f) and (g) address timing requirements. Subdivision (f) requires that "For non-emergency services, the MPN applicant shall ensure that an appointment for the first treatment visit under the MPN is available within 3 business days of a covered employee's notice to an MPN medical access assistant that treatment is needed." This three-business-day standard applies to initial primary care appointments and represents a legal floor below which MPN administrators cannot fall. Subdivision (g) extends to specialist appointments: "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 initial appointment with a specialist in an appropriate referred specialty is available within 20 business days of a covered employee's reasonable requests for an appointment through an MPN medical access assistant."[8] Critically, the same subdivision includes a gap-filler: "If an MPN medical access assistant is unable to schedule a timely medical appointment with an appropriate specialist within ten business days of an employee's request, the employer shall permit the employee to obtain necessary treatment with an appropriate specialist outside of the MPN."

The regulation also addresses Medical Access Assistant (MAA) requirements. CCR Section 9767.5(h) specifies that "MPN medical access assistants shall be located in the United States and shall be available, at a minimum, from Monday through Saturday from 7 am to 8 pm, Pacific Time, to provide employee assistance with access to medical care under the MPN. The employee assistance shall be available in English and Spanish." This requirement appears straightforward but has proven difficult to verify in practice, as documented below.

Definition, Purpose, and Operational Structure of Medical Provider Networks

Core Function and Legal Definition

A Medical Provider Network, as defined by the California Division of Workers' Compensation, is "an entity or group of health care providers set up by an insurer or self-insured employer and approved by DWC's administrative director to treat workers injured on the job." This definition captures the essential elements: MPNs are employer or insurer-sponsored (not state-operated or employee-selected), must be approved by state regulatory authority, and serve the specific purpose of treating work-related injuries and illnesses. The definition distinguishes MPNs from other managed care arrangements in California workers' compensation, such as Health Care Organizations (HCOs) certified under Labor Code Section 4600.5, which operate under different regulatory frameworks and include state-employed providers subject to different accountability mechanisms.

The statutory purpose of MPNs combines cost containment with access assurance. Labor Code Section 4616(a) states the goal: "The provider network shall 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." This language reflects a policy determination that employers should be permitted to select providers-potentially negotiating more favorable rates than the statewide workers' compensation fee schedule-but only if they ensure that injured employees

retain meaningful access to necessary care. The quid pro quo is explicit: in exchange for the right to restrict provider selection, the MPN must maintain access standards and allow employee choice.

One consequence of this statutory structure is that once an injured employee's employer establishes an approved MPN, the employee's care automatically comes under MPN governance unless a statutory exception applies. An employee cannot elect out of the MPN based on personal preference or provider familiarity; the law requires that "all medical care for workers injured on the job whose employer has an approved MPN will be handled and provided through the MPN" with limited exceptions.[9] This mandatory requirement represents a significant restriction on employee autonomy compared to traditional workers' compensation systems where injured workers select their own physicians subject to employer approval after thirty days.

Establishment, Approval, and Operational Authority

Under Labor Code Section 4616(b), "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." The application process is governed by CCR Section 9767.2 and related sections, which specify required documentation. An MPN application must include a cover page signed by the applicant's authorized representative, verified legal name, correct tax identification number, estimated number of claims, provider directories with required geocoding analysis, and evidence that the MPN meets access standards through mapping and distance calculations.

The approval timeline is defined by Labor Code Section 4616(b): "If the administrative director does not act on the plan within 60 days of submitting the plan, it shall be deemed approved." In practice, this creates a binding deadline for DWC review. However, if an application is incomplete or deficient, the sixty-day clock may restart upon the submission of supplemental information. Once approved, an MPN receives a four-year approval period, with reapproval required no later than six months before expiration. MPNs approved prior to January 1, 2014 that did not comply with updated regulations had until January 1, 2018 to update their plans; this transition period has long since passed, though some MPNs continue to operate under older approval dates.

Who may establish an MPN is defined by Labor Code Section 4616 and CCR Section 9767.1: "A workers' compensation insurer, self-insured employer, joint powers authority, the State of California, California Insurance Guarantee Association (CIGA), State Compensation Insurance Fund (SCIF), a group of self-insured employers and an entity that provides physician network services." This language is significant because it permits third parties-"entities that provide physician network services"-to establish networks on behalf of insurers or employers. In practice, this has created complex MPN structures where a third-party entity (sometimes a subsidiary of a larger managed care or third-party administration company) holds the MPN approval, while the actual insurer or employer utilizes the network. This structure has generated enforcement challenges when the relationship between the approved MPN entity and the utilizing insurer becomes unclear.

The authority to modify or terminate an MPN is addressed in CCR Section 9767.8. Material modifications-defined to include changes to geographic service area, continuity of care policy, transfer of care policy, or compliance methodology-must be submitted and approved by the DWC before implementation. Non-material modifications may be implemented concurrently with notification to the DWC. This distinction between material and non-material modifications has created disputes regarding whether specific changes (such as addition or removal of particular providers, adjustment of access areas, or changes to the MPN contact procedure) constitute modifications requiring pre-approval.

Access Standards, Geographic Requirements, and Provider Availability

Primary Treating Physician Access Standards

The foundational access requirement is articulated in CCR Section 9767.5(a)(1): an MPN must have "at least three available primary treating physicians 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 30 minutes or 15 miles of each covered employee's residence or workplace." This standard is absolute-not

subject to variation based on the employer's size, industry, or location, except where the MPN explicitly proposes alternative standards under subdivision (b). The three-physician minimum reflects a legislative judgment that injured workers should have meaningful choice among providers, and that a single provider or even two providers might create practical access barriers (scheduling conflicts, provider vacancies, need for continuity during temporary absences).

The measurement standard-"30 minutes or 15 miles"-gives primacy to travel time but provides a distance fallback. The use of "or" rather than "and" means that an MPN satisfies the requirement if it meets either standard at a given location. However, CCR Section 9767.15(b) requires that MPN applicants provide geocoding results demonstrating compliance with access standards "determined by the injured employee's residence or workplace address and not the center of a zip code." This geocoding requirement has become one of the most significant compliance mechanisms, as it allows DWC to verify that access standards are met on a granular, address-specific basis rather than assuming that providers are adequately distributed throughout a geographic area.

The requirement for an "emergency health care services" provider or hospital within the same access standard (30 minutes/15 miles) addresses the reality that occupational injuries sometimes require immediate stabilization. CCR Section 9767.5(j) separately requires that "The MPN applicant shall have a written policy to allow an injured employee to receive emergency health care services from a medical service or hospital provider who is not a member of the MPN." This carve-out means that an injured worker who sustains a severe injury requiring emergency room care is not restricted to MPN providers in emergency settings-a limitation that would be both dangerous and legally indefensible.

Specialist Access Standards

Access standards for specialists operate under a different geographic threshold: CCR Section 9767.5(a)(2) requires providers within "60 minutes or 30 miles" of the employee's residence or workplace. This more generous standard reflects recognition that specialist services are less frequently required than primary care, and that geographic consolidation of specialists in larger facilities is both economically inevitable and medically appropriate. However, the regulation further specifies that the MPN must have "at least three available physicians of each specialty to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged."

The phrase "each specialty" and the industry-specific qualifier have generated important case law. In Murillo v. Western National Group (2021), the Workers' Compensation Appeals Board (WCAB) clarified that an injured employee seeking treatment from a specialist must satisfy the specialist access standard (30 miles/60 minutes), not the more restrictive primary care standard. The WCAB explained that "if an injured worker wants to be treated by a specialist, the access standards for specialist should apply," and held that an MPN satisfies the requirement if it includes three physicians within the specialist access standard, even if no specialists of that type are available within primary care distances. This interpretation dramatically affects the practical availability of specialty care, as it means that patients in areas without nearby pain management specialists (as in the Murillo case) may be required to travel further than the primary care standard, or may need to pursue formal dispute resolution to establish that no appropriate specialist is available.

The determination of which specialties are "common injuries experienced by injured employees based on the type of occupation or industry" is left to the MPN applicant's clinical judgment, subject to DWC review. This creates flexibility for industry-specific networks but also permits arguable underestimation of specialty needs. An MPN serving construction workers presumably must include orthopedic surgeons given the frequency of orthopedic injuries; an MPN for office workers might justify lesser orthopedic resources but greater availability of providers for repetitive strain injuries.

Appointment Availability and Timing Requirements

Beyond geographic standards, CCR Section 9767.5(f) mandates timing benchmarks for appointment availability. For non-emergency services, the first treatment visit must be available within three business days of the employee's notice to the MPN medical access assistant that treatment is needed. This three-day standard is absolute and does not contain exceptions for holidays, high-volume periods, or provider

unavailability. If the MPN cannot schedule an appointment within three days, it technically fails the regulatory requirement, though practical enforcement depends on whether the employee documents the delay and timely raises it as a dispute.

For specialist appointments, CCR Section 9767.5(g) sets a twenty-business-day standard, but includes an important safety valve. If the MAA cannot schedule an appointment with an appropriate specialist within ten business days, "the employer shall permit the employee to obtain necessary treatment with an appropriate specialist outside of the MPN." This provision recognizes that long waits for specialty care can undermine the therapeutic purpose of the MPN system and creates a mechanism for employees to access outside care without requiring formal dispute resolution.

The regulatory framework also addresses the duty of the MPN to accommodate outside-the-network care when necessary. CCR Section 9767.5(c) states: "If a covered employee is not able to obtain from an MPN physician reasonable and necessary medical treatment within the applicable access standards in subdivisions (a) or (b) and the required time frames in subdivisions (f) and (g), then the MPN shall have a written policy permitting the covered employee to obtain necessary treatment for that injury from an appropriate specialist outside the MPN within a reasonable geographic area." This language creates a backup right to external care when the MPN fails its access obligations, though practically, asserting this right often requires documentary evidence of the MPN's failure to meet appointment timeframes.

Alternative Access Standards for Underserved Areas

CCR Section 9767.5(b) recognizes geographic realities that may prevent strict compliance with the fifteen-mile and thirty-mile standards in certain areas: "If an MPN applicant believes that, given the facts and circumstances with regard to a portion of its service area, specifically areas in which there is a health care shortage, including non-rural areas and rural areas in which health facilities are located at least 30 miles apart, the accessibility standards set forth in subdivisions (a)(1) and/or (a)(2) cannot be met, the MPN applicant may propose alternative standards of accessibility for that portion of its service area." This provision allows flexibility for rural areas and other health professional shortage areas (HPSAs), but requires that the alternative standards be expressly proposed, justified, and approved as part of the MPN application or reapproval process.

Northern California contains significant geographic variation that qualifies for alternative standards consideration. The Bay Area, greater Sacramento, and major urban corridors meet standard distance requirements, but rural portions of the service areas-particularly in the Sierra Nevada foothills, coastal regions, and less-populated inland areas-may legitimately qualify for modified access standards. Labor Code Section 4616(a)(2) explicitly directs the Administrative Director to "consider the needs of rural areas, specifically those in which health facilities are located at least 30 miles apart." This statutory recognition provides the regulatory foundation for alternative standard proposals in sparsely populated regions.

Finding, Selecting, and Changing Treating Physicians within an MPN

The Medical Access Assistant and Provider Selection Process

The primary mechanism for injured workers to locate MPN physicians is the Medical Access Assistant (MAA), whose role is defined in CCR Section 9767.5(h). The MAA must be located within the United States and available at minimum Monday through Saturday, 7 am to 8 pm Pacific Time, to assist injured workers in finding providers. Notably, the regulation specifies that MAAs must be available in both English and Spanish, reflecting the demographic composition of California's workforce. The MAA is distinct from the claims adjuster; while both may be employed by the same claims administrator, the regulation requires that "MPN medical access assistants have different duties than claims adjusters" and that "if the same person performs both, the MPN medical access assistant's contacts must be separately and accurately logged."

In practice, the MAA's duties include responding to injured workers' requests for provider information, providing lists of available physicians matching the worker's injury type and geographic location, assisting with appointment scheduling, and maintaining records of inquiries and placements. However, documented evidence from multiple sources indicates that this system fails in practice with disturbing frequency. One

detailed case study describes an attempt to identify an eligible MPN physician through multiple channels: starting with the DWC's official MPN list, then attempting to access the MPN's stated website, finding only generic landing pages, and ultimately being unable to reach a functional MAA service. Similar problems are reported by injured workers attempting to navigate third-party vendor systems (such as Talis Point, Enlyte/Coventry, or CorVel platforms) that purport to display MPN directories but often display outdated provider lists, non-functional search functions, or landing pages without access to the specific MPN in question.

The initial treatment appointment occurs with a Primary Treating Physician (PTP) selected by either the injured worker (exercising choice within the MPN) or, in the case of the very first appointment, potentially by the claims administrator. CCR Section 9767.6(a) specifies: "Unless the covered employee has predesignated a personal physician or the predesignation rights are suspended, the claims administrator shall notify the covered employee of the names, addresses, and telephone numbers of at least three available primary treating physicians from which the employee may select." This requirement mandates that the claims administrator provide a meaningful list of alternatives, not a single referral. After the first appointment, the injured worker may change PTPs: "A covered employee may change primary treating physicians within the MPN at any time without the claims administrator's permission."

The process of changing physicians is administratively distinct from the initial selection. An employee who wishes to change from one MPN physician to another must notify the claims administrator (or more typically, the medical access assistant) and select a new PTP from the available roster. Unlike HCO systems where transfers are subject to clinical approval, MPN transfers are strictly employee-driven after the initial visit. However, if the new PTP is concerned that the case is outside their scope of practice, they may decline to accept the patient, requiring the employee to select another provider.

Pre-Designation of Personal Physicians

One of the most important exceptions to the mandatory MPN requirement is pre-designation of a personal physician under Labor Code Section 4600(d) and CCR Section 9783. An employee may pre-designate a personal physician at any time before an injury occurs, and if the pre-designation meets statutory requirements, the pre-designated physician becomes the treating physician even if the employer has an MPN. The requirements are restrictive: the physician must be the employee's "regular physician" (defined as one limited to general practice or board-certified/board-eligible in internist, pediatrician, obstetrician-gynecologist, or family practice specialties), the physician must have "previously directed your medical treatment, and retained your medical records," the employee must have current non-occupational health care coverage through the same physician, and both the employee and physician must have provided written notice to the employer before the injury occurs.

The pre-designation form, DWC Form 9783, is available in English and Spanish and must be completed by the employee, signed, and delivered to the employer. The physician's signature is required on the form, though the regulation permits other evidence of the physician's agreement if the physician does not sign the form directly. Pre-designation provides a significant protection for employees who have long-standing relationships with personal physicians and wish to avoid MPN assignment. However, the requirement that the physician agree in writing creates a potential barrier if physicians are unwilling to commit to treating work injuries or if they practice in settings (such as fee-for-service models or certain managed care plans) where workers' compensation treatment is not integrated into their practice.

An important distinction exists between pre-designated physicians who are MPN members and those who are not. If an employee pre-designates a physician who is a member of the employer's MPN, the employee may receive care from that physician, but the episode remains subject to MPN rules regarding specialist referrals, utilization review, and dispute resolution mechanisms. If the pre-designated physician is not an MPN member, the physician operates entirely outside the MPN framework, subject only to general workers' compensation medical treatment rules and utilization review requirements that apply to all non-MPN treatment.

Specialist Referrals and Referral Authority

Injured workers' access to specialist care within MPNs is governed by both MPN regulations and traditional workers' compensation utilization review requirements. When an MPN primary treating physician refers an injured worker to a specialist, the referral enters the utilization review system. If the referring physician lacks specialist privileges within the MPN, or if the referred specialist is outside the MPN, questions arise about whether the MPN's access standards apply and whether the claims administrator may deny the referral based on MPN-membership grounds.

CCR Section 9767.5(i) addresses this scenario: "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." This provision creates a critical gap-filler: if the PTP identifies a clinical need for specialist consultation in a field where the MPN has no providers (or where the MAA cannot schedule an appointment within required timeframes), the employee has the right to seek the specialist outside the network. The claims administrator may still apply utilization review to the specialist's proposed treatment, but cannot deny the out-of-MPN referral based on MPN-membership grounds alone.

The process of selecting a specialist when multiple options exist within the MPN is governed by specialist access standards, as clarified in the Murillo decision discussed above. If a specialist field is available within the MPN and meets the thirty-mile/sixty-minute access standard, the employee is generally required to select from MPN specialists, though the three-physician minimum ensures meaningful choice.

Second and Third Opinions

An injured worker's right to second and third opinions within an MPN is established by Labor Code Section 4616.3(c): "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." The regulation does not require a specific articulated disagreement with the treating physician's clinical judgment; in the recent decision In re Williamson v. Claims Administrator, the WCAB clarified that "an applicant's failure to articulate a specific objection to the treating physician's diagnosis and treatment recommendations did not preclude him from obtaining a second opinion consultation."

The second opinion process is detailed in CCR Section 9767.7. The employee's responsibility is to: (1) notify the employer or claims administrator of the dispute in writing or orally; (2) select a physician from a list of available MPN providers provided by the employer; and (3) make an appointment within sixty days of receiving the provider list. The employer's responsibility includes providing "at least a regional area listing of MPN providers and/or specialists" appropriate to the dispute, informing the employee of the right to request medical records, and notifying the second opinion physician of the nature of the dispute. If the employee fails to schedule the appointment within sixty days, the right to the second opinion is deemed waived with respect to that particular dispute.

The second opinion physician renders a written opinion addressing the disputed diagnosis or treatment and may recommend alternative approaches. If the second opinion physician determines that the case is outside their scope of practice, the employer must provide a new list of available physicians for the employee to select from. Importantly, the second opinion consultation does not require utilization review or pre-authorization; it is a statutory right that may be invoked independent of whether the treating physician's recommendation has been authorized.

If the employee disputes the second opinion physician's findings, a third opinion can be pursued using the identical process. If the employee disputes the third opinion, the final step is to request an MPN Independent Medical Review (MPN-IMR) under Labor Code Section 4616.4 and CCR SectionSection 9768.1-9768.9. The MPN-IMR process differs from the standard utilization review IMR process; it is specific to disputes arising within MPN contexts and involves selection of an independent medical reviewer from a specialized panel, with consideration of the employee's preference for geographic proximity (within thirty miles, with increasing search radiuses if necessary).

Coverage for Physical Injuries and Occupational Illnesses

Acute Occupational Injuries and the Role of MPNs

California workers' compensation law recognizes occupational injuries as any injury arising out of and occurring in the course of employment, whether acute or cumulative. For acute injuries-a hand laceration from equipment, a back strain from lifting, a leg fracture from a fall-the MPN serves as the gateway to medical care. Once an employer establishes an approved MPN, injured workers with acute injuries are required to receive treatment through the MPN unless they have pre-designated a personal physician or fall within another statutory exception.

The types of acute injuries most commonly managed through MPNs include traumatic orthopedic injuries (fractures, dislocations, ligament tears), crush injuries, burn injuries, occupational lacerations, and acute neurological trauma. The MPN's composition must reflect these common injuries through availability of orthopedic surgeons, emergency physicians, and other trauma specialists. In construction, agriculture, and manufacturing settings, the MPN typically includes more extensive orthopedic resources than in office-based industries.

The treatment pathway for an acute injury within an MPN begins at the first medical visit to an MPN-approved emergency room, urgent care facility, or primary care physician. The provider documents the injury, performs initial examinations and imaging, and initiates treatment. If hospitalization is required, the MPN's emergency care exception (CCR Section 9767.5(j)) permits treatment at any hospital without MPN restriction, though subsequent inpatient care falls back under MPN governance. Once the acute phase stabilizes and the worker enters recovery and rehabilitation, the MPN framework regulates ongoing care, specialist consultations, and authorization of advanced imaging, surgical procedures, and ancillary services.

Occupational Diseases and Cumulative Trauma Conditions

Occupational diseases-conditions resulting from repeated exposure to workplace hazards rather than a single accident-are addressed under Labor Code Section 5307.1 (currently Section 5307) and create different evidentiary requirements than acute injuries, but operate within the same MPN framework once the disease is accepted as compensable. Cumulative trauma conditions, such as carpal tunnel syndrome from repetitive keyboarding, epicondylitis from repetitive gripping, or lower back strain from sustained heavy lifting, represent the majority of occupational disease claims in many industries.

The treatment of occupational diseases within MPNs requires specialists trained in occupational medicine. An injured worker with work-related carpal tunnel syndrome, for example, would typically require evaluation by an occupational medicine physician or hand surgery specialist who understands the relationship between workplace activities and the condition. The MPN's requirement to include "providers of occupational health services and specialists who can treat common injuries experienced by the covered injured employees based on the type of occupation or industry in which the employee is engaged" directly addresses these cumulative trauma cases.

An important nuance appears in the Murillo decision regarding specialist selection in occupational disease cases. An employee with a work-related condition requiring specialist care must demonstrate, if challenged, that the specialist is treating a condition arising from the occupational injury. The specialist access standard (thirty miles/sixty minutes) applies, not the more restrictive primary care standard, but the MPN must include specialists treating the relevant medical condition.

Ancillary Services and Non-Physician Provider Coverage

Beyond physician-provided care, MPNs must address ancillary services-diagnostic imaging, physical therapy, occupational therapy, durable medical equipment (DME), home health care, and other non-physician services. CCR Section 9767.5(d) addresses ancillary service availability: "If an MPN provides ancillary services and those services or goods are not available within a reasonable time or a reasonable geographic area to a covered employee, then the employee may obtain necessary ancillary services outside of the MPN within a reasonable geographic area." This provision permits MPNs to provide comprehensive services, including ancillary care, without imposing the same strict access standards that govern physician services.

Historically, California workers' compensation law has permitted a broad range of allied health professionals to provide compensable treatment. Chiropractors and acupuncturists are specifically addressed in the MPN regulations. CCR Section 9767.1 requires that "MPNs must include acupuncturists and chiropractors as providers if they are commonly used by the employees being treated." This industry-specific requirement reflects recognition that certain occupations rely extensively on chiropractic care for musculoskeletal conditions. Conversely, an MPN serving office workers might justify limited chiropractic resources if the employee population has low utilization of such services.

Ancillary care represents a substantial portion of workers' compensation medical costs-estimated at approximately thirty percent of total medical spend across the industry. The major categories include physical therapy (PT) and occupational therapy (OT), which address functional recovery and return-to-work outcomes; diagnostic imaging (X-ray, MRI, CT, ultrasound), which guides treatment decisions; durable medical equipment and supplies (braces, orthotics, crutches); home health services for immobilized or severely disabled workers; and vocational rehabilitation services. These services are essential to achieving the workers' compensation system's dual goals of adequate medical care and timely return to work.

Coordination of ancillary services within MPNs is managed through the network's structure. Some MPNs subcontract with specialized ancillary care networks (such as CorVel's ancillary care solutions or similar third-party arrangements), while others directly credential ancillary providers within their physician network. The regulation permits this flexibility so long as the services meet the availability and access standards. An injured worker whose PT provider must delay an appointment beyond reasonable timeframes may access PT outside the MPN, with the costs remaining the employer's responsibility.

Coverage for Non-Physical and Psychological Occupational Injuries

Legal Recognition of Occupational Illnesses and Stress-Related Claims

California law explicitly recognizes occupational illnesses resulting from non-physical workplace stressors, though proof requirements are more stringent than for physical injuries. Labor Code Section 3208.3 establishes that injury from stress is compensable "if the employee proves by clear and convincing evidence that the employee sustained an occupational disease or injury caused by stress occurring in the performance of a duty of the employment." The statute also requires that "the employment by the employer is the predominant cause of the injury or illness." This "predominant cause" and "clear and convincing evidence" standard creates a higher bar than for physical injuries, where causation can often be established through temporal proximity to the work event.

The types of workplace stress-related injuries recognized in case law include anxiety disorders, depressive disorders, post-traumatic stress disorder (PTSD), and adjustment disorders arising from occupational circumstances. Classic scenarios include first responders (police officers, firefighters, paramedics) exposed to critical incidents or traumatic events in the course of duty; healthcare workers experiencing cumulative exposure to patient trauma or critical care situations; employees subjected to ongoing harassment, discrimination, or unlawful personnel actions; and employees facing sudden job loss or significant adverse employment actions.

An important distinction exists between physical injury producing psychological consequences (which requires showing that the physical injury caused the psychiatric symptoms) and pure psychological injury (which requires showing that workplace stressors caused the injury independent of any physical trauma). A construction worker who sustains a workplace injury, undergoes surgery, experiences chronic pain, and develops depression from the chronic pain condition faces a different evidentiary pathway than a worker alleging that workplace stress management practices caused depression absent physical injury.

MPN Coverage and Treatment of Psychological Injuries

The California workers' compensation system has progressively expanded acceptance of psychological injury claims, and MPNs must accommodate treatment of these conditions. The MPN's provider requirements address psychological care through inclusion of psychiatrists and psychologists. CCR Section 9767.1 specifies that licensed providers are to be included in the MPN, and the statute lists "psychologists"

as eligible providers, alongside physicians, surgeons, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners. Additionally, MPNs may include "ancillary service providers such as physical therapists," but the focus on psychological treatment is on the primary provider-the psychiatrist or psychologist who provides evaluations and ongoing therapy.

Treatment authorization for psychological injuries within an MPN requires that the injury meet the statutory definition of occupational disease or injury under Labor Code Section 5307 (for conditions arising from repeated stressors) or Section 3208.3 (for injury caused by stress). Once accepted as compensable, the injured worker accesses psychological treatment through the MPN in the same manner as physical injury treatment. The claims administrator provides a list of MPN psychiatrists or psychologists, the employee selects a provider, and treatment proceeds subject to utilization review of proposed interventions.

The MPN's access standards apply to psychological care provision: the employee must be able to access a psychiatrist or psychologist within the applicable geographic and timing standards. For primary mental health treatment, the fifteen-mile/thirty-minute standard applies; for specialty psychological services (such as trauma-focused cognitive behavioral therapy or other evidence-based treatments for PTSD), the thirty-mile/sixty-minute specialist standard applies. These distance requirements are particularly significant for psychological injury cases, as the availability of trauma-informed providers who specialize in occupational PTSD may be limited in certain geographic areas.

Integrated Physical-Psychological Treatment and Cumulative Harm Models

Many workers' compensation injuries involve both physical and psychological components. A worker with a chronic pain condition may develop anxiety or depression directly resulting from the chronic pain, the functional limitations it imposes, or the extended treatment course itself. The MPN must accommodate treatment of both components simultaneously, which requires coordination between the physician managing pain (typically orthopedic surgeon, pain management specialist, or physiatrist) and the psychologist or psychiatrist addressing psychological sequelae.

Cumulative trauma cases involving occupational disease frequently produce psychological components. A worker with decades of repetitive occupational stress-such as a teacher facing escalating classroom discipline challenges, a nurse experiencing repeated exposure to critical care situations, or a corrections officer subjected to chronic workplace violence exposure-may develop recognized psychiatric conditions. The predominant cause requirement under Section 3208.3 requires clear evidence that the workplace stress was the predominant cause, not pre-existing mental health vulnerabilities or non-work stressors.

Quality of Mental Health Evaluation and Expert Witness Requirements

For disputed psychological injury claims, the MPN framework incorporates qualified medical evaluator (QME) evaluations and, when applicable, agreed medical evaluator (AME) assessments. The evaluating physician (either QME or AME) must be licensed as a medical doctor (M.D.) or doctor of osteopathic medicine (D.O.), not a psychologist, though psychiatrists may serve as QME/AME. Psychologists may provide medical-legal opinions supporting workers' compensation claims through specialized evaluation protocols, often coordinated with the QME process, but the formal medical determination role is reserved to licensed physicians.

For injured workers seeking to maximize their psychological injury claim, expert psychological testimony is often essential. California case law has established that psychologists, social workers, and counselors can provide credible evidence supporting psychiatric diagnoses and causation. The evaluation should address the worker's functional impairment (using standardized instruments such as the Global Assessment of Functioning scale), the temporal relationship between workplace stressors and symptom onset, alternative causative factors, and specific workplace events or conditions that caused distress.

Types of Medical Providers and Treatment Modalities within MPNs

Physician Specialties Required by Industry and Injury Type

The MPN regulations require that MPNs include an "adequate number and type of physicians" appropriate to the industry and types of injuries expected. This requirement compels MPN applicants to analyze their

covered employee population and design networks accordingly. An MPN serving construction workers, for example, must include orthopedic surgeons, trauma surgeons, hand surgeons, and occupational medicine physicians. An MPN serving office workers might justify different specialty composition, potentially with greater emphasis on occupational medicine, ergonomics specialists, and psychological healthcare.

The primary care physicians in an MPN typically include internists, family practitioners, and occupational medicine physicians. These providers serve as gatekeepers for the system, conducting initial evaluations, ordering diagnostic testing, and determining when specialist consultation is needed. The requirement for three available primary care physicians within fifteen miles/thirty minutes ensures that injured workers have choice among primary providers and are not dependent on a single clinician.

Beyond primary care, the major specialty disciplines represented in most MPNs include orthopedic surgery (addressing fractures, joint injuries, and musculoskeletal trauma), general surgery (for lacerations, crush injuries, and other trauma requiring surgical intervention), neurosurgery (for spinal cord injuries and traumatic brain injuries), urology (for occupational injuries to genitourinary systems), ophthalmology (for ocular trauma and chemical eye injuries), otolaryngology (for head and neck trauma), psychiatry and psychology (for psychological injuries and stress-related conditions), physical medicine and rehabilitation/physiatry (for functional recovery and pain management), and pain management specialists (including anesthesiologists with pain management credentials).

Licensed Professional Status and Scope of Practice

The statutory framework permits MPNs to include providers beyond physicians. California Labor Code Section 4616(a)(1) specifies that the MPN "shall include physicians," but CCR Section 9767.1 permits inclusion of "Licensed physicians and providers of medical services," which include "physicians, surgeons, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners." Each of these provider categories has defined scope of practice under California law.

Psychologists in California must be licensed by the Board of Psychology and hold a doctoral degree (Ph.D. or Psy.D.). Within workers' compensation, psychologists may provide psychological evaluation, testing, and therapy for occupational injuries and illnesses. However, psychologists cannot prescribe medications (except limited prescriptions in certain cases under California law), which creates a gap for injured workers who require both psychological counseling and pharmacological treatment for psychiatric conditions. This gap is typically addressed by referral to a psychiatrist (who is an M.D. with psychiatric specialization and can prescribe medications) for medication management while the psychologist continues psychotherapy.

Acupuncturists must be licensed by the California Acupuncture Board and, since 2020, must hold either a Master's degree in acupuncture or have completed a minimum of 3,000 hours of training. Within workers' compensation, acupuncture is an approved treatment modality for certain conditions, particularly musculoskeletal pain and occupational illnesses. The MPN must include acupuncturists if they are "commonly used by the employees being treated," creating an obligation to include acupuncture in networks serving populations likely to utilize this treatment.

Chiropractors must be licensed by the State Board of Chiropractic Examiners and hold a Doctor of Chiropractic (D.C.) degree. Workers' compensation law permits chiropractic treatment for musculoskeletal occupational injuries, with certain limitations (such as the restriction that a chiropractor cannot be an employee's personal physician after the employee has received twenty-four chiropractic visits, unless the physician holds specific qualifications). MPNs serving manual labor industries typically include chiropractors as part of the musculoskeletal treatment team.

Podiatrists must be licensed by the Board of Podiatric Medicine and hold a Doctor of Podiatric Medicine (D.P.M.) degree. They are included in MPNs when foot and ankle injuries are anticipated-relevant for workers in occupations involving standing, climbing, or repetitive foot stressors.

Optometrists, holding a Doctor of Optometry (O.D.) degree and licensed by the Board of Optometry, are included to address visual injuries from occupational hazards such as chemical exposure, foreign body injuries, or trauma.

Ancillary Service Providers and Physical Rehabilitation Specialists

In addition to primary and specialty physicians, MPNs include extensive networks of ancillary service providers. Physical therapists (PT) and occupational therapists (OT), licensed by the Physical Therapy Board and Occupational Therapy Board respectively, are essential to the MPN's rehabilitation mission. These professionals typically hold Master's degrees (increasingly, Doctor of Physical Therapy degrees) and provide evidence-based functional rehabilitation aimed at restoring worker capacity and facilitating return to work.

Durable medical equipment (DME) suppliers provide mobility aids, braces, orthotic devices, and medical equipment necessary for patient care. These vendors are typically credentialed through the MPN and must maintain quality standards and appropriate pricing to ensure that DME costs do not become excessive relative to clinical benefit.

Home health agencies provide skilled nursing care, physical therapy, occupational therapy, and other services to injured workers unable to travel for outpatient care. These services are particularly important for workers with mobility limitations or those in rural areas distant from clinical facilities.

Diagnostic service providers-imaging centers, laboratory facilities, electromyography (EMG) testing centers-are credentialed within MPNs to ensure availability of diagnostic testing needed to guide treatment decisions. The MPN's role in coordinating diagnostic services helps avoid unnecessary or redundant testing while ensuring that clinically indicated imaging and laboratory studies are accessible.

Treatment Modalities and Medical Necessity Standards

The scope of treatments available through MPNs is governed by two standards: the Medical Treatment Utilization Schedule (MTUS) established pursuant to Labor Code Section 5307.27, and, where MTUS is silent or inapplicable, the American College of Occupational Medicine (ACOM) Occupational Medicine Practice Guidelines. These treatment guidelines establish which interventions are considered appropriate for specific conditions, what duration of treatment is anticipated, and when continuation of treatment requires justification through utilization review.

For orthopedic injuries, the MTUS and ACOM guidelines address non-surgical interventions (rest, ice, anti-inflammatory medications, physical therapy, injections), surgical decision points, and rehabilitation protocols. Treatment typically progresses through conservative management before advancing to surgical intervention, though acutely unstable injuries may require surgery earlier in the course.

For pain management, guidelines address appropriate use of analgesic medications, interventional pain procedures (joint injections, nerve blocks, spinal cord stimulation), and psychological approaches to pain. The opioid crisis has prompted restrictions on long-term opioid prescribing in workers' compensation, with guidelines now emphasizing multimodal pain management and functional restoration.

For occupational diseases and cumulative trauma conditions, treatment protocols address ergonomic modifications, activity modification, therapeutic interventions, and surgical options when conservative approaches fail. The evidence-based guidelines tend to be more conservative for occupational diseases than for acute injuries, reflecting recognition that these conditions often have prolonged courses requiring extended treatment.

For psychological injuries, treatment protocols address psychotherapy modalities (cognitive-behavioral therapy, trauma-focused therapy, acceptance and commitment therapy), psychotropic medications, and rehabilitation aimed at restoring functional capacity and return to work. The MTUS and ACOM guidelines for psychological injury are less prescriptive than for physical injuries, reflecting the individualized nature of mental health treatment.

Medical Provider Networks by Insurance Carrier and Structural Variations

Major Insurance Carriers and Custom MPN Designs

California's workers' compensation market includes multiple insurance carriers operating approved MPNs. As of February 2026, the Division of Workers' Compensation's active MPN list identifies over 2,400 individual MPNs across the state. However, the vast majority are inactive, suspended, or terminated, leaving approximately 194 actively maintained MPNs managed by actual employers and insurers. The most prominent carriers with substantial Northern California presence include State Fund California (the state compensation insurance fund), Hartford Fire Insurance Company, CorVel, Coventry Health Care, PMA Companies, and numerous regional and specialty carriers.

Each major carrier structures its MPN differently based on its underwriting philosophy, client base, and geographic footprint. State Fund California, as the state-operated carrier serving employers without private insurance, maintains a geographically comprehensive MPN covering all California regions with integrated occupational medicine services. Private carriers often differentiate their MPN offerings by industry specialization. Hartford's MPN includes specialized networks for construction, healthcare, manufacturing, and other high-hazard industries. Carriers specializing in professional liability or high-income professionals may offer smaller, more selective networks emphasizing musculoskeletal care and psychological services.

Third-Party Administration and MPN Vendor Relationships

The regulatory landscape permits "entities providing physician network services" to establish MPNs on behalf of insurers or employers. In practice, this has created complex vendor relationships. Major third-party administrators (TPAs) like Sedgwick, Broadspire, and others often subcontract with specialized MPN vendors to manage network operations. A single insurance carrier might utilize different MPN vendors in different regions or for different client groups, creating confusion regarding the applicable MPN, the correct contact information for the medical access assistant, and the actual provider directory.

This layered structure has generated significant problems for injured workers. In some documented cases, the employer's initial injury notice form identifies an MPN and contact information, but that information is inaccurate or leads to a vendor that no longer manages that MPN. Injured workers and their representatives must navigate a confusing landscape to identify the correct MPN entity, locate functioning provider directories, and reach the MAA. This navigation problem affects both the initial identification of available providers and subsequent disputes over whether the MPN meets access standards.

Geocoding Requirements and Access Standard Compliance Documentation

Beginning with regulatory amendments effective in 2014, the DWC implemented a geocoding requirement for MPN applications and reapprovals. MPNs seeking approval must now submit electronic geocoding results demonstrating that their provider networks meet access standards on a location-specific basis. The required geocoding submissions include separate Excel files showing: (1) a complete list of zip codes in the MPN's service area; (2) analysis of whether at least three primary treating physicians are available within the fifteen-mile standard from the center of each zip code; (3) analysis of hospital and emergency care provider locations; (4) analysis of specialist availability; and (5) identification of any zip codes where access standards are not met.

This geocoding requirement theoretically creates accountability for MPN compliance with access standards. An MPN cannot claim to meet standards through general assertions about provider availability; it must provide granular geographic data demonstrating that access requirements are met at specific locations. However, the data is only as accurate as the provider information submitted, and as discussed below, many MPNs maintain outdated provider directories that include inactive or deceased physicians.

Electronic Directories and Provider Verification Systems

MPNs are required to maintain provider directories accessible to covered employees. The regulation requires that MPNs provide "a printed directory or an electronic directory available to each covered employee upon request, giving the names, addresses, telephone numbers and specialties of all available MPN physicians and other providers available to treat covered employees." Additionally, the directory "shall include the name and address of each hospital or emergency health care facility in the MPN" and information about how injured workers can access the medical access assistant.

In practice, MPN provider directories exist in multiple formats: printed directories mailed to employers, PDF directories on the MPN's website, searchable databases accessible through the MPN vendor's portal, and electronic listings available through third-party platforms. The quality and currency of these directories vary dramatically. Some carriers maintain real-time updated directories; others operate with outdated provider lists that include physicians who no longer participate in the MPN or who have retired from practice.

The problem is compounded by the vendor relationships described above. An injured worker seeking to access the State Fund MPN provider directory may visit the State Fund website and locate a directory; the same worker's employer may receive a different directory from a third-party administrator; and the claims adjuster managing the case may reference yet another directory maintained by a TPA's MPN management vendor. These multiple versions of the "official" directory frequently contain discrepancies.

Regional and Industry-Specific Network Variations

MPNs often vary by geographic region and industry served. The DWC's active MPN list shows significant concentration of approved networks in urban areas-particularly the Bay Area, greater Los Angeles, and the Central Valley-while more sparse network options exist in rural regions. Some MPNs operate statewide; others are limited to specific regions or counties.

Industry-specific MPNs include networks designed for construction, agriculture, transportation, healthcare, and other high-risk sectors. A construction MPN might include more orthopedic surgeons, occupational medicine physicians, and occupational health specialists compared to a network serving administrative workers. The flexibility in network design, while supporting industry-specific medical management, also creates complexity for injured workers unfamiliar with their employer's industry classification within the MPN framework.

Dispute Resolution Mechanisms and Independent Medical Review Processes

Utilization Review and Initial Dispute Resolution

When an injured worker's treating physician recommends medical treatment, the claims administrator conducts utilization review (UR) to determine whether the treatment meets medical necessity standards under applicable treatment guidelines. Utilization review is distinct from MPN membership review; a treating provider can be authorized to provide treatment even if not an MPN member, and conversely, MPN membership does not guarantee authorization of all treatments proposed.

If the claims administrator denies or modifies the treatment authorization through UR, the injured worker and treating physician receive an Explanation of Review (EOR) detailing the denial rationale and referencing the guidelines applied. Within thirty days of receiving the UR denial, the worker may request an Independent Medical Review (UR-IMR) under Labor Code Section 4610.6. This UR-IMR process is distinct from the MPN-specific independent medical review (MPN-IMR) discussed below.

The UR-IMR process involves submission of an application to Maximus (contracted by the state to administer UR-IMRs), assignment of an IMR physician from a panel of licensed physicians certified in the relevant specialty, and the IMR physician's decision within thirty days of receiving all relevant medical documents. The IMR physician must follow medical treatment guidelines and render a decision addressing whether the disputed treatment is medically necessary. If the IMR physician agrees that treatment is necessary, the claims administrator must authorize the treatment within five business days.

Second and Third Opinion Process Within the MPN

The MPN-specific dispute resolution begins with the second opinion process described earlier under CCR Section 9767.7. An injured worker who disputes the treating physician's diagnosis or treatment may request a second opinion from another MPN physician. This second opinion right is statutory and does not require that a UR denial first occur; an injured worker may invoke the right proactively without waiting for an authorization decision.

The process requires that the employer provide a list of at least three available MPN physicians or specialists appropriate to the dispute. The employee selects one, notifies the employer of the appointment date, and the second opinion proceeds. The second opinion physician renders a written opinion within twenty days of the appointment, addressing the disputed diagnosis or treatment and proposing alternative approaches if appropriate.

If the employee disputes the second opinion, a third opinion can be pursued using identical procedures. The third opinion physician again provides written findings and alternative recommendations. Notably, the regulations do not permit a fourth or subsequent opinion; once the third opinion is issued, the dispute resolution pathway within the MPN framework is exhausted (unless the employee chooses to pursue UR-IMR instead).

MPN Independent Medical Review (MPN-IMR)

If the employee disputes the third opinion physician's findings, the next step is MPN Independent Medical Review under Labor Code Section 4616.4 and CCR SectionSection 9768.1-9768.9. The MPN-IMR is a distinct process from UR-IMR, involving selection of an independent medical reviewer from a specialized panel, written notice to the employee of the reviewer's identity, and an opportunity for the employee to object based on conflicts of interest.

The administrative director's selection process prioritizes geographic proximity: "If the covered employee requests an in-person examination, the Administrative Director shall randomly select a physician from the panel of available Independent Medical Reviewers, with an appropriate specialty, who has an office located within thirty miles of the employee's residence address, to be the Independent Medical Reviewer." If only one qualified physician is within thirty miles, that physician is selected. If none exist within thirty miles, the search expands in five-mile increments until a physician is located.

Once assigned, the MPN-IMR physician has up to thirty days to schedule an in-person examination (if requested by the employee) or will conduct a record review (if the employee requests review-only). The employee may contact the IMR to request an appointment, and has sixty days from receiving the IMR's name to schedule the exam; failure to schedule within sixty days waives the MPN-IMR right. The IMR's decision is issued to the employee, treating physician, MPN contact, and claims administrator, and addresses whether the disputed diagnosis or treatment is appropriate based on medical necessity standards.

Interaction Between MPN Dispute Procedures and Utilization Review

A practical question arises regarding the interaction between MPN-specific dispute resolution (second/third opinion and MPN-IMR) and the general utilization review/UR-IMR process. The regulations and case law clarify that these are parallel, not sequential, processes. An injured worker may pursue second and third opinions within the MPN independently of whether a UR denial has been issued. Conversely, if a treatment recommendation has been denied through UR, the worker may seek UR-IMR without exhausting the MPN second/third opinion process.

However, practical sequencing considerations suggest that many injured workers initially attempt MPN second and third opinions before resorting to UR-IMR, since the MPN process permits the worker to select providers personally and may be faster. Alternatively, an injured worker might pursue UR-IMR if the claims administrator has already denied authorization, as the UR-IMR process directly addresses medical necessity. The choice between processes involves strategic considerations: the MPN process emphasizes clinical opinion comparison, while UR-IMR emphasizes explicit application of treatment guidelines.

Continuity of Care and Transfer of Injured Workers Into MPNs

Treatment Completion for Pre-MPN Injuries

An important protection exists for injured workers whose injuries occurred before the MPN coverage became effective or before the employer's MPN was implemented. Labor Code Section 4616.2 and CCR Section 9767.9 address the situation where a treating provider is not a member of the newly implemented MPN. In such cases, the employer may be required to permit treatment completion with the existing provider under specific circumstances.

CCR Section 9767.9(e) specifies the conditions under which completion of treatment with a non-MPN provider is authorized: (1) a serious chronic condition as defined by CCR Section 9767.9(e)(2)-a medical condition persisting beyond ninety days requiring ongoing treatment; (2) a terminal illness as defined by CCR Section 9767.9(e)(3); (3) performance of a surgery or procedure authorized and documented as part of the employee's treatment course, to occur within 180 days of the MPN effective date; or (4) transfer of a previously injured employee into a newly implemented MPN where the injury does not meet the chronic condition or terminal illness definitions.

For serious chronic conditions, completion of treatment is authorized for a period up to one year "to complete a course of treatment approved by the employer or insurer" and "to arrange for transfer to another provider within the MPN, as determined by the insurer, employer, or entity that provides physician network services." This recognition of serious chronic conditions protects injured workers engaged in long-term treatment (such as for chronic pain conditions, serious orthopedic injuries, or complex psychological conditions) from abrupt discontinuation of care.

The process requires that the employer or claims administrator provide written notice in English and Spanish to the injured worker, explaining the medical determination regarding whether the condition meets the continuity of care exception. If the injured worker disputes the determination-claiming that their condition is actually a serious chronic condition contrary to the employer's position-the dispute is resolved under Labor Code Section 4062 (medical dispute procedures), not through the MPN dispute mechanisms.

Continuity of Care Policy Requirements

Every MPN must include a written continuity of care policy addressing how the network will handle situations where providers are terminated or no longer available. The policy must address the circumstances under which injured workers may continue treatment with a terminated provider and the process for arranging safe transitions to continuing providers within the network.

The PRISM MPN's continuity of care policy, included in the research sources, exemplifies the regulatory requirements. It specifies that completion of treatment with a terminated provider is authorized for serious chronic conditions (up to twelve months), terminal illnesses (for the duration), and authorized surgeries within 180 days of contract termination. Additionally, the policy addresses compensation for terminated providers continuing to treat: they must be compensated at rates comparable to actively contracting providers in the same geographic area, "unless otherwise agreed by the terminated provider and the employer or its claims administrator."

If the provider is terminated for cause (disciplinary action, fraud, or criminal activity), the continuity of care protections do not apply, and the injured worker must transition immediately to a continuing network provider. This carve-out reflects the principle that injured workers should not be compelled to continue treatment with providers subject to disciplinary actions.

Challenges, Limitations, and Practical Implementation Barriers

Documented Problems with Provider Directory Accuracy and Accessibility

Despite regulatory requirements for provider directories, multiple sources document serious deficiencies in directory accuracy and accessibility. One detailed case study describes an attempt to locate an eligible MPN provider through multiple channels: accessing the state's official MPN list, navigating to the listed MPN website, finding only generic landing pages, attempting to access provider directories, encountering non-functional search functions, and ultimately being unable to reach a functioning Medical Access Assistant despite repeated attempts. The case study identifies a pattern where the claims administrator, the insurer, the MPN entity, and various third-party vendors each maintain different versions of the provider directory or contact information, creating frustration and preventing injured workers from locating care.

Another documented problem involves provider directories that include physicians no longer in active practice. Geocoding submissions may reference physicians who have retired, moved to other states, or deceased, artificially inflating the apparent availability of providers in a given geographic area. The DWC's current system for monitoring provider currency is insufficient to prevent these inaccuracies.

The problem is compounded by vendor layering. An injured worker insured by Insurer A, whose workers' compensation policy is administered by TPA B, whose MPN is managed by MPN Vendor C, receives information about the MPN from the insurer (which may reference outdated contact information) and the employer (which may reference different information). The injured worker calling the listed MAA phone number reaches a general administrative line that cannot specifically address MPN provider availability.

Enforcement and Compliance Monitoring by the DWC

The DWC's ability to monitor and enforce MPN compliance has historically been limited. The agency is understaffed relative to the volume of approved networks and the complexity of access standard verification. While the geocoding requirement represents a significant step toward accountability, the accuracy of geocoding submissions depends on the timeliness and accuracy of provider rosters submitted by MPNs-a dependency that assumes good faith compliance.

The agency has limited formal enforcement tools beyond denial of MPN renewal. An MPN found to violate access standards could theoretically have its approval suspended or terminated, but such actions are rare. Instead, complaints about MPN access failures are typically addressed through individual disputes between injured workers and claims administrators, with the injured worker bearing the burden of documenting access failure and pursuing formal remedies.

Recent regulatory amendments, proposed in February 2025, suggest recognition of these problems. The DWC has indicated intention to invite stakeholder comment on proposed updates to MPN regulations and rules for medical treatment billing, suggesting potential revisions to address documented compliance issues.

Geographic Disparities and Rural Access Barriers

Rural areas throughout California face systematic MPN access challenges. Many rural counties have fewer than ten approved, active MPNs, and those networks may have limited specialist availability or extended wait times exceeding regulatory standards. Alternative access standards proposed by MPNs serving rural regions attempt to address these realities, but injured workers in areas where alternative standards have not been approved may find themselves unable to access required care within standard timeframes.

The Northern California region includes significant rural areas-particularly the Sierra Nevada foothills, the far north coast, and inland regions-where MPN provider availability remains a practical barrier to access. Some rural MPNs have successfully proposed and implemented alternative standards that accommodate the geographic realities of sparse physician distribution. However, injured workers in regions where alternative standards have not been implemented may be legally required to travel extended distances to access MPN-required care.

Discrepancies Between MPN Membership and Authorization Status

A documented problem involves claims administrators denying payment for treatment provided by physicians claimed to be outside the MPN, even when the MPN in question does not exist, is not currently approved, or does not include the provider in question. In one documented case, a claims administrator authorized treatment through UR, then denied payment claiming the provider was not in the applicable MPN-despite the DWC's records showing that the MPN applicant (the insurer) had no approved MPN at all.

This pattern suggests confusion (or occasionally deliberate misrepresentation) regarding the relationship between MPN membership and treatment authorization. Utilization review and MPN membership are theoretically independent determinations: a treatment can be authorized through UR regardless of provider MPN status, and conversely, MPN membership provides no assurance of authorization. However, in practice, some claims administrators use MPN non-membership as a secondary basis for payment denial, creating confusion for providers.

Time and Resource Requirements for Dispute Resolution

The multiple dispute processes available to injured workers-second and third opinions within the MPN, MPN-IMR, UR-IMR, and ultimately medical-legal evaluation under Labor Code SectionSection 4061-

4062-require time and administrative effort. An injured worker contesting a treating physician's recommendation might spend months navigating second and third opinions, waiting for MPN-IMR assignment and scheduling, and then pursuing additional disputes through utilization review or medical-legal processes. During this period, the injured worker may be denied access to the disputed treatment, potentially delaying recovery.

The sixty-day timeframes for scheduling second and third opinion appointments and MPN-IMR examinations can pass quickly, particularly if the employee does not actively track deadlines or if the MPN or MAA provides inaccurate timeframe information. Failure to meet these deadlines results in waiver of the specific dispute mechanism, leaving the employee with limited remedies.

Conclusion and Practical Recommendations for Navigating the MPN System

Summary of Key Findings

California's workers' compensation Medical Provider Network system represents a significant but imperfect mechanism for managing occupational medical care. The statutory and regulatory framework, grounded in Labor Code Section 4616 and implementing regulations in CCR SectionSection 9767.1-9767.19, creates mandatory access standards that theoretically ensure injured workers receive timely care from adequately diverse provider networks. The access standards-three available primary care physicians within fifteen miles or thirty minutes, specialists within thirty miles or sixty minutes, first appointment availability within three business days, specialist appointment availability within twenty business days-establish measurable benchmarks for adequacy.

In practice, the system operates unevenly across different geographic regions, injury types, and carrier implementations. Urban areas with concentrated populations generally meet access standards; rural areas face systematic shortfalls. Common occupational injuries (orthopedic, occupational medicine) have adequate provider networks; subspecialties may require patients to travel or pursue external treatment. Large carriers with substantial California footprints maintain relatively current provider directories and functional MAA services; smaller carriers and third-party vendors struggle with directory accuracy and accessibility.

The dispute resolution mechanisms-second and third opinions within the MPN, MPN-IMR, and UR-IMR-provide injured workers with formal pathways to challenge denial or inappropriate restriction of treatment. However, these processes require time, documentation, and persistence. The burden falls substantially on injured workers and their representatives to navigate the system, verify provider availability, and initiate formal disputes when access barriers emerge.

Coverage for both physical occupational injuries and non-physical injuries (psychological conditions, occupational diseases) is legally mandated and typically available within MPNs, though specialized providers for occupational stress-related conditions may be limited in certain areas. The integration of ancillary services-physical therapy, occupational therapy, diagnostic imaging, durable medical equipment-within MPN structures supports functional recovery and return-to-work objectives, though access to these services can be restricted through MPN limitations.

Practical Recommendations for Injured Workers

Verify MPN Status Early: Upon sustaining a work injury, injured workers should confirm whether their employer has an approved MPN by contacting the employer, reviewing any workers' compensation notices provided, and if necessary, checking the DWC's active MPN list directly. Understanding the applicable MPN allows the worker to know what provider options are available and what dispute mechanisms are available if access barriers emerge.

Contact the Medical Access Assistant Directly: Rather than relying on employer-provided contact information or employer selection of providers, injured workers should proactively contact the MPN's Medical Access Assistant within the first few days after injury. Clearly explain the type of injury, request a list of at least three available providers, and ask about appointment availability. Document the date and

time of the call, the name of the MAA representative (if provided), and the provider list or information received.

Document Everything: Maintain detailed records of all communications regarding provider selection, appointment scheduling, and access barriers. If the MAA cannot schedule an appointment within the legally required timeframes (three business days for primary care, twenty business days for specialist), document the specific dates of requests and the reasons provided for unavailability. This documentation becomes critical if the worker later needs to pursue formal dispute resolution or seek external provider care.

Pre-Designate a Personal Physician Before Injury: If employed and not covered by an MPN, or if working in a position where injury is possible, consider pre-designating a personal physician using DWC Form 9783. This must be completed and signed by both the employee and physician before any occupational injury occurs. If accomplished, the pre-designated physician becomes the treating provider regardless of MPN requirements.

Request Second and Third Opinions Proactively: If dissatisfied with a treating physician's diagnosis or proposed treatment, do not wait for a formal UR denial. Instead, invoke the statutory right to second and third opinions under Labor Code Section 4616.3. Notify the claims administrator in writing, request a list of at least three MPN physicians appropriate to the dispute, and select a physician for the second opinion. This process is faster than waiting for UR denial and subsequent UR-IMR.

Understand Your Specialist Rights: If referred to a specialist, confirm that the specialist is within MPN access standards (thirty miles/sixty minutes). If the MAA cannot schedule an appointment within ten business days, you have the right to obtain specialist care outside the MPN at the employer's expense. Exercise this right if necessary to obtain timely care.

Seek Legal Assistance for Complex Claims: For serious injuries requiring extended treatment, occupational disease claims requiring industry-specific medical management, or psychological injury claims requiring proof of causation, consider consulting with an experienced workers' compensation attorney or workers' compensation advocate. These professionals can navigate the dispute mechanisms, advocate for treatment access, and coordinate medical-legal evaluations supporting your claim.

Practical Recommendations for Employers and Claims Administrators

Maintain Current Provider Directories: Regularly verify that all physicians listed as MPN providers are active, appropriately credentialed, and willing to treat occupational injuries. Implement processes for removing retired or relocated physicians from directories within sixty days of departure. Provide updated directories to covered employees at least annually.

Ensure Medical Access Assistant Functionality: Verify that the MAA service is operational, that personnel assigned to MAA duties are properly trained on MPN procedures, and that MAA communications are documented and logged separately from claims administration duties. Implement call-tracking systems to ensure that MAA calls are answered within reasonable timeframes and that employees receive accurate, current provider information.

Implement Geocoding Analysis: For MPNs approaching four-year reapproval deadlines, begin geocoding analysis early to identify any geographic areas where access standards are not met. Develop plans to either add providers to underserved areas or, if justified, propose alternative access standards with supporting documentation of health care shortage conditions.

Coordinate with Third-Party Vendors: If using third-party MPN vendors to manage network operations, establish clear accountability mechanisms. Require vendors to provide updated provider lists at specified intervals, to maintain functioning MAA services, and to track access standard compliance. Conduct periodic audits of vendor performance to verify that injured workers can actually locate and access care.

Communicate Clearly with Injured Workers: Provide clear, detailed information about MPN structure, MAA contact information, and the process for selecting providers. Ensure that initial injury notices include accurate, current information about how to access care. Offer Spanish-language materials and services reflecting the state's diverse workforce.

Practical Recommendations for Healthcare Providers

Verify MPN Status Before Treatment: Before treating an injured worker, confirm whether the patient is covered by an MPN and, if so, whether you are a participating provider. Obtain confirmation of MPN membership and current authorization procedures from the claims administrator. Clarify whether you will accept the MPN's fee schedule and whether the MPN's prior authorization procedures will be followed.

Participate in Provider Networks Strategically: For physicians considering MPN participation, evaluate the network's patient volume, fee schedule adequateness, prior authorization procedures, and dispute resolution mechanisms. MPNs offering below-market compensation or burdensome prior authorization procedures may not be worth the administrative overhead.

Document Access and Appointment Barriers: If injured workers contact your office requesting appointments but your schedule cannot accommodate them within regulatory timeframes, document the requests and scheduling barriers. If multiple injured workers are unable to access your care within required timeframes, this indicates that the MPN may be underestimating demand and may need provider expansion.

Future Regulatory Directions

The DWC's recent indication that it is considering regulatory updates to MPN requirements and medical treatment billing rules suggests potential future developments. Injured workers and employers should monitor proposed amendments for clarifications regarding access standard enforcement, provider directory accuracy, and MAA functionality. Participating in DWC stakeholder processes-through advocacy organizations, professional associations, or individual comments-can influence the direction of these regulatory refinements.

The fundamental tension underlying the MPN system-balancing employer cost containment against injured worker access and choice-will likely continue to generate regulatory and judicial attention. As the system evolves, the dual requirements of adequate access and meaningful provider choice should remain central to any regulatory modifications.

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