Medical Legal Fee Schedule Forum Comments

Steve Cattolica July 10, 2020
CWCSA

Please click here in order to view Mr. Cattolica's comments.

Eduardo Lin, MD July 10, 2020

Thank you for allowing to express my comments regarding future changes of QME.

It is critical to continue allow QME to do testing on QME patients. Specifically EMG/NCS, electromagnetic and nerves conduction study.

As EMG/NCS is recommended by ACOEM guideline for diagnosis testing purposes. EMG/ NCS is also recommended by AMA guide to impairment rating book 5th edition for impairment rating purposes.

Not able to do such tests during QME examination only will delays and prolonged resolution of QME. And ultimately it will cost more to insurance and employers.

Accurate diagnoses and testing will let to proper treatments. It will allow faster resolution of cases. As well more focus on specific treatments.

Accurate diagnosis and testing will also unable QME to recommend specific rating purposes.

Delaying of EMG/NCS testing only will increase the cost of case. As without accurate diagnosis it will take longer time to receive appropriate treatments.

For example a 55 years old women food packer who developed neck, wrists and hands pain associated with numbness and tingling sensation. Physical examination showed local tenderness in the wrists and forearms associated with decreased of hands gripping strength. Positive tinnel's and Phallen test and local tenderness of wrists. So patient was diagnosed with repetitive strain injury plus bilateral wrists tendinitis. Does he have nerves entrapment injuries like carpal tunnel syndrome or ulnar nerve entrapment injury at elbow? Or nerve root injury in the neck of cervical radiculopathy?

So EMG/NCS can be very helpful to make accurate diagnosis and treatments recommendations. So testing will save cost to system And allow treatments.

So patient can received specific treatments for the finding better faster and return to working with proper diagnosis.

Each specific diagnosis and finding will also provide specific rating of injury as recommended by AMA guide.

Please do not remove authority of QME of performing EMG/NCS.

Many thanks DWC.

Bradley Bower, MD July 10, 2020

YET ANOTHER EXERCISE IN FUTILITY

As I search for the DWC website for the relatively cryptic series of links (how appropriate) leading one to the DWC forum page, one may take notice of the DWC's mission statement as it relates to workers' compensation and their commitment [yeah, right] to the CA employees and employers:

The Division of Workers' Compensation (DWC) monitors the administration of workers' compensation claims, and provides administrative and judicial services to assist in resolving disputes that arise in connection with claims for workers' compensation benefits. DWC's mission is to minimize the adverse impact of work-related injuries on California employees and employers.

The DWC's effort (or more appropriately lack of effort) to promote a substantive revision of the med-legal fee schedule directly undermines their alleged mission as referenced above. The DWC's actions here will impair the resolution of disputes in the WC system, as well as increase the adverse impacts of work work-related injuries to CA employees and employers.

This is now the third forum, all of which clearly evoke a widely negative response from the QME community. The most recent exercise in mediocrity soliciting feedback from the QME community took place nearly one year ago. After this prolonged "effort," the DWC returns with a proposed fee schedule that represents nothing more than a watered down version of the Nevada med-legal fee schedule (with lesser reimbursement). From an amusement standpoint however, I do appreciate the addition of the inappropriate punitive measures and work-for-free requirements; these are very special and welcome additions.

It is clear that the most recent proposal undermines alleged efforts that were made in the context of stakeholder collaboration to construct a fee schedule that would be somewhat more viable, at least in theory; clearly, the DWC is not making a good faith effort to resolve this matter. During the past two forums, I formulated detailed communications (void of any generic cut and paste content) that were submitted with

the intent of contributing to the forward movement of this process. It's now apparent I should have been spending my time in a more productive manner (for example, herding my cats), as few, if any of the concerns that have been submitted by the QME community have been substantively addressed.

A Few Observations / Opinions

(1) Med-Legal Evaluation Costs have not increased for years.

The WCIRB provides an annual report on the WC costs. Payments for med-legal evaluations have remained relatively flat if not reduced since at least 2014. The percentage of total medical payments attributed to med-legal evaluations by year is as follows:

2014: 6.6%; 2015: 6.9%; 2016: 7.6%; 2017: 6.7%; 2018: 6.1%; 2019: 6.3%

The average cost of med-legal reports by year is as follows:

2016: $1660; 2017: $1500; 2018: $1470; 2019:$1482 (Yes, they have decreased)

Assuming an average inflation rate of 2.12% annually and a cumulative inflation rate of 6.52% from 2016 to 2019 (yeah, right), the average amount spent on a report from 2016 to 2019 has decreased from 1768 -1482 = $286.

(2) Med-Legal Evaluations are produced along a spectrum of quality (and it's not a bell-shaped curve)

If the DWC and other stakeholders have concerns about the quality of QME reports, the approach that is currently being taken to manage the fee schedule ain't gonna make it any better. In my opinion, many QME reports fail to meet the standard of substantial evidence. The reports are commonly non-explanative, lack data to support conclusions, and amount to nothing more than speculation. Often, reasoning to support conclusions is either absent or of poor quality. QME's that generate reports that meet the standard must spend significant amounts of time and energy formulating reports that all parties can understand and utilize to move any given case forward. Demonstrable medical research is often required. These individuals will be forced with a decision to either work for $50-100/hour (or less) or move on to other positions where their time is valued; this decision will be clear for many.

(3) When properly constructed, the QME Report is a powerful tool to promote case resolution.

In the absence of availability of adequate numbers of QME physicians, friction in the WC system will increase even more, leading to prolongation of cases and increased

costs. This is a “no-brainer.” A reduction in the fee schedule with the addition of punitive measures will leave a pool of largely unqualified providers that will produce highly suboptimal reports, which will in turn lead to highly suboptimal outcomes for all parties involved, including the insurers.

(4) The DWC’s past actions have been demonstrably underhanded, if not illegal.

A number of concerns have evolved over time. The DWC’s undermining of the recent stakeholder process is evident. The DWC’s pathologic alliance with insurer interests has been demonstrated previously. The previous punitive actions of the DWC against QME physicians has largely been viewed as illegal.

If there are legitimate concerns with the QME processes, the DWC should give consideration to embrace legitimate processes to address them.

AND IN CLOSING

I could go on, but time for submission draws near. I purposely procrastinated on the formulation of this communication and submission to the forum, hoping to avoid the expenditure of valuable time toward a process that has been governed by lack of transparency and distrust. As the midnight hour approaches, I must remind myself of the time I must spend on activities that have a much higher likelihood of success and positive outcome - I got to go herd my cats!

Robert Aptekar July 10, 2020

I have carefully reviewed and considered the below recommended alterations to the current MLFS proposal and fully concur with them:

- All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation

- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.

- The fee schedule should include an **automatic annual COLA increase for QMEs**. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.

- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)

- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report

- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

David Alvarez
3DIMS, LLC

July 10, 2020

In the proposed changes to the Medical-Legal Fee Schedule the writers did not take into account other regulations or cases that may be more complicated than a basic evaluation that the new recommended fees allow. It appears that the DWC has taken the side of the Insurance carrier in a cost cutting effort only to increase their profits. The *Medical Expert* is being short changed and shown to be unappreciated in a system that they are heavily relied upon to resolve injured workers' claims and get them back into the workplace. Below are recommendations that I hope are really reviewed and addressed by the DWC, et al.

First and foremost, under 9793:

9793(j) is in regard to "Medical Research" but the new proposed fee schedule does not address this at all. Medical Research is vital in some cases for evaluators to be able to prove or disprove a contested claim. Based on current times imagine a physician reporting that a specific medication can cure a specific illness or disease with no scientific evidence of such and an evaluator who performs their due diligence finds scientific information that in fact the medication is detrimental to the injured worker. Why wouldn't the evaluator be able to be reimbursed for his due diligence? Why does the DWC demean or dismiss "Medical Research" by ignoring it in the proposed fee schedule? Does the DWC not believe in scientific evidence to prove or disprove a claim whether contested or not?

Possible to create a modifer for research that can be used for increase in billing and can be used x number of times based on topics covered in the report. An example modifer 9x added to a ML code times 2 based on research used by Psychiatrist who provided research material on PTSD and Schizophrenia.

Secondly, under 9794:

9794(b) it should be amended to include language that will protect the evaluator when claims administrator does not respond in 60 days to state that Penalty and Interest will be automatically included when payment is made. Currently claims administrators try to pass the blame on bill review and vice versa. Some carriers claim that the physician has to bill for it and submit it for payment. Why does an evaluator have to do additional work to be reimbursed for something that he is entitled to and had no control over the delay? Insurance carriers use this as a way to avoid paying the fees since they know some evaluators will not request it due to the additional work involved. The Penalty and interest fees should also be increased to prevent claims administrators from abusing this regulation.

9794 (c) if the claims administrator contests a bill and does not pay for the uncontested portion it should include language that failure to pay uncontested

amount will result in forfeiture of right to object and payment along with penalty and interest will be made in full.

9794 (g) it should also hold the claims administrator accountable and if they fail to respond within 90 days, they shall be required to pay the amount in full along with penalty and interest.

Thirdly, under 9795:

9795 ML200 the fees for medical record review based on number of pages should be higher for the minimum amount and instead of giving a discount for additional pages that fee should actually increase. *Do labor laws allow for an employer to pay less to an employee for working overtime? No, they do not in fact they are required to pay overtime and if they are found to be violating overtime pay the are fined, so why should an evaluator expect to be paid less when putting more time in than the minimum?*

9795 ML201 the fees for ~~Comprehensive~~ *Basic* Medical-Legal Evaluation should be allowed to be for what the title states. Why is a comprehensive evaluation being reimbursed at a flat rate? Why isn't the DWC taking into account complexity that may be involved, i.e. multiple body parts, multiple dates of injuries, etc. *This type of evolution should be named Basic Medical-Legal Evaluation NOT Comprehensive.*

With regard to medical record review based on number of pages the proposed fee should be higher for the cases where the minimum amount is exceeded instead of giving a discount for additional pages that fee should actually increase. *Do labor laws allow for an employer to pay less to an employee for working overtime? No, they do not in fact they are required to pay overtime and if they are found to be in violation overtime pay laws the are fined, so why should an evaluator expect to be paid less when putting more time in than the minimum?*

9795 ML202 ~~Follow-up Medical-Legal Evaluation~~ *Comprehensive Medical-Legal Evaluation* with RV of ~~81~~ *248* ($4030). This would actually reflect the comprehensive reports that involve multiple body parts, dates of injury, that require addressing them in an appropriate manner in compliance with reporting guidelines and regulations.

With regard to medical record review based on number of pages the proposed fee should be higher for the cases where the minimum amount is exceeded instead of giving a discount for additional pages that fee should actually increase. *Do labor laws allow for an employer to pay less to an employee for working overtime? No, they do not in fact they are required to pay overtime and if they are found to be in violation overtime pay laws the are fined, so why should an*

evaluator expect to be paid less when putting more time in than the minimum?

9795 ML203 Fees for ~~Supplemental Medical-Legal Evaluations~~ *Follow-up Medical-Legal Evaluation with RV of ML202*. The code and procedure description used on ML204 should be applied here.

Again, with regard to medical record review based on number of pages the proposed fee should be higher for the cases where the minimum amount is exceeded instead of giving a discount for additional pages that fee should actually increase. *Do labor laws allow for an employer to pay less to an employee for working overtime? No, they do not in fact they are required to pay overtime and if they are found to be in violation overtime pay laws the are fined, so why should an evaluator expect to be paid less when putting more time in than the minimum?*

9795 ML204 ~~Fees for Medical-Legal Testimony Fees~~ Supplemental Medical-Legal Evaluations, the code and procedure description used on ML204 should be applied here.

With regard to statement of "(1) ~~information which was available in the physician's office for review….physician prior to preparing a comprehensive medical-legal report~~…" and it should read (*1) information…physician at the time of the evaluation."* A physician should not be held accountable for not having the entire medical file and correspondence from the parties or having to wait for a claims administrator, attorneys to come to an agreement on what is relevant which causes delays in sending the information prior to scheduled evaluation for the injured worker. There have been numerous cases where the correspondence on what to address or medical records arrive after the scheduled evaluation of the injured worker preventing the evaluator from properly questioning the information provided by the injured worker. The 10-day record rule should be completely eliminated and claims administrator and or attorneys should be held accountable in having the entire medical file in the hands of the evaluator prior to the scheduled evaluation.

With regard to failure to issue a supplemental report the wording should recognize that a contested bill by the claims administrator does not apply. An evaluator should have the right to delay a supplemental report while the issue is being addressed in compliance with 9794 (b)(c)(d)(e)(f)(g). In many cases the claims administrator denies a claim because they do not have a clear path of communication with the attorney representing them. On one occasion I had a claims administrator deny a bill because the amount of records that she had in her system (2 inches) did not match the 20 inches submitted by the defense attorney she accused the evaluator of overbilling and fraud which was not the case. We had to submit the cover letter by the

defense attorney with the medical index and copies of the UPS ticket that showed the 2 boxes sent to us. Why does the evaluator get penalized for something that the claims administrator clearly does not have a handle on? Why does the DWC always look to discipline the evaluator but does not hold the claims administrator, insurance carrier, or attorney accountable?

With regard to medical record review based on number of pages the proposed fee should be higher for the cases where the minimum amount is exceeded instead of giving a discount for additional pages that fee should actually increase. *Do labor laws allow for an employer to pay less to an employee for working overtime? No, they do not in fact they are required to pay overtime and if they are found to be in violation overtime pay laws the are fined, so why should an evaluator expect to be paid less when putting more time in than the minimum?*

ML205 Fees for ~~review of Sub Rosa Recordings~~ Medical-Legal Testimony.
The code and procedure description used on ML204 should be applied here.

The RV of this code should be higher than that of ML202 for a Missed Appointment. The recommended RV should be 10 resulting in an appropriate reimbursement.

Code should also include language under "The physician shall be entitled to fees for all…." that allows for the evaluator to bill for time spent in reviewing the deposition transcript. This is to allow a physician to make necessary corrections to a legal document that can be used in court made by the transcriptionist present during the deposition.

In regard to statement "The physician shall be paid a minimum of two hours for a deposition" than why can he not be reimbursed for the same two hours if a deposition is cancelled or rescheduled?

Statement should read as follows "If a deposition…, the physician shall be paid a minimum of ~~one~~ *two* hour*s* for the scheduled deposition."

A statement also needs to be added to the statement "The physician shall be paid a minimum of two hours for a deposition *in the form of a retainer once the deposition is scheduled. Cancellations or rescheduled depositions not in compliance with the specified time frame will result in forfeiture of the fees."*

Attorney responsible for payment of scheduled deposition should also be informed to arrive with an additional check to cover time spent in the deposition in excess of the minimum two hours.

ML 206 ~~Remedial Supplemental Medical-Legal Evaluations~~. Fees for review of Sub Rosa Recordings. The code and procedure description used on ML205 should be applied here.

In regard to statement "If the sub rosa recordings are received by a physician ~~prior to~~ *after* the ~~issuance of a pending report~~ *evaluation* related to a medical-legal evaluation, the physician may ~~not~~ also bill a supplemental report fee in connection with the review of the Sub Rosa material.

Physician should not be penalized for delays made by the referring parties. Any and all records whether received on paper, sub rosa, etc. received after the date of evaluation should be addressed in a supplemental report and allowed to be billed accordingly because it can cause a physician to have to revisit and alter the initial thought process and reporting that they may already have based on what one would consider new information.

ML 207 Remedial Supplemental Medical Legal Evaluations. The code and procedure description used on ML205 should be applied here.

"…provided to the physician prior to the scheduled ~~preparing a~~ comprehensive medical- legal ~~report~~ *evaluation* or a follow-up medical-legal *evaluation*, (2) …"

Physician should not be penalized for delays made by the referring parties. Any and all records whether received on paper, sub rosa, etc received after the date of evaluation should be addressed in a supplemental report and allowed to be billed accordingly because it can cause a physician to have to revisit and alter the initial thought process and reporting that they may already have based on what one would consider new information. The physician would not be able to question the injured worker if there are any discrepancies between records and history provided.

9795 (d) The description should INCLUDE all ML CODES LISTED. All modifiers should reflect the change from just evaluation code to all codes. *Why would an AME be entitled to increase in reimbursement only for evaluation but not anywhere else, i.e. supplemental report or deposition?* Defeats the purpose of parties moving forward with an AME.

I hope that the DWC, Stakeholders and the Workers' Compensation community takes into account the above information as well as comments others have made in order to have a successful WC system that does not punish the Medical Expert but actually takes them into account, acknowledges them and compensates appropriately. WC premiums, PDs have increased over the years but not the Medical Legal fees which is an integral component to the system.

Praveen Kambam, MD, QME July 10, 2020

The following are some of my concerns regarding the proposed fee schedule:

Psychological and psychiatric QME interviews and reports will not be adequately compensated by a 1.5 modifier. This will result in the attrition of psych QMEs, especially psychiatrists, as this pay will not compensate the number of hours required at a competitive rate. The modifier needs to be at least 2.5 to 3.0, and, at the lower rate, should include additional modifiers for Rolda and any past psych claims. The psych modifier should apply not only to the base rate but also to record review as the content of the records is frequently more dense including past psychiatric records, personnel records and other documentation. The regulations even hold psych QMEs to a higher level of record review than other specialists, requiring them to review records personally, which further warrants the modifier being applied to record review as well as the base rate.

It makes no logical sense that records 1801 and beyond will take less time to review than the first 1800 pages. There should be a flat fee for all pages of $3.25 for all pages reviewed, which is consistent with the proposed new hourly rate of $325 an hour. There also needs to be clear stipulation that double sided pages count as two pages, condensed depositions count as 4 pages, and a standard page size is 8.5x11.

Doctors need to receive records before the evaluation in order to perform a comprehensive history gathering. At the very least the cut off should be the day of the evaluation. If we are required to include records received at any time prior to issuing of the report, this is bound to cause delays in reporting and even late reports, which will just complicate the system, causing delays, denied reports, and requests for new panels.

A period of 24 months is too long to be considered a re-evaluation. The amount of records and interim information can be extensive and the re-evaluation rate is inadequate for this. The span should be no more than 12 months.

There must be a COLA included with the fee schedule so that the rate that QMEs are paid does not rapidly become inadequate, bringing us back to the problems that is occurring now.

George W. Than, DC July 10, 2020

Re: per page charges of $2 and $3

Required Bate Stamping of documents provided to the QME for review is forensic and really a minimum. Plus, it helps all parties to document charges and payment. Please consider this as a reasonable requirement that would really help all parties.

Richard Rogachefsky, MD July 10, 2020

After review of the proposed new fee schedule I am not in agreement with the proposed $3 per page up to 1000 pages and then $2 per page for pages more than 1000. The page re-imbursement should be at least $3 per page above 200 pages. It is the same amount of work to review pages up to 1000 as it is to review pages of records over 1000. The re-imbursement for record review should be at least $3 per page for all pages above 200 pages.

With regards to annual increase, there should be a small increase each year for increase in cost of living.

The vast majority of the time records are not sent to the QME by the evaluation and are sent later which makes the QME evaluation more difficult and the QME report less complete. There should be a requirement that the records are sent to the QME 1 week prior to the evaluation so the QME has time to process and review the records or penalties will be placed on the involved parties responsible for providing the records.

Thank you for your attention to these important matters.

Jay Martin July 10, 2020

I have worked for doctors who do medical-legal evaluations in Workers' Comp for several years, and have more recently been working with a highly experienced and well-regarded Qualified Medical Examiner and Agreed Medical Examiner in Psychiatry practicing in Southern California.

As proposed, this prohibitive fee schedule would mean that the psychiatrist I work for would be unable to produce the kind of reports needed by Workers' Compensation. Without being fairly compensated for the doctor's time on an hourly basis, like other psychiatrists and psychologists, like the lawyers with whom the doctor works, and like other professionals, the doctor would no longer be able to work as either an AME or as a PQME, and I would be out of a job.

The doctor pointed out Labor Code 5307.6 to me. It's stated that doctors should receive "…fees which provide remuneration to physicians performing medical-legal evaluations at a level equivalent to that provided to physicians for reasonably comparable work, and which additionally recognizes the relative complexity of various types of evaluations, the amount of time spent by the physician in direct contact with the patient, and the need to prepare a written report."

This flat fee schedule is impractical, confusing, open to misrepresentation and misinterpretation. Ultimately, it is unworkable. I would understand that, for psychiatrists, instead of a raise, this would be a major decrease in payment, where the doctor fears having to close the office.

I appreciate the opportunity to comment upon these changes and express my concerns for the far-reaching consequences of this proposal.

Michelle Conover, Ph.D., QME July 10, 2020
Neuropsychologist/Brain and Behavior Specialist

The new fee schedule will unfortunately is not acceptable in regards to all the many hours that we put in to construct a comprehensive and value added report. If the fees are reduced you will be forcing the evaluators to cut corners in order for the time to match up because, lets be honest, no one wants to work for minimum wage.

This will lead to an increase of misdiagnoses, which does not benefit anyone. This will cause an avalanche of more depositions and supplemental reports, not to mention causing undue harm to the injured worker who deserves the highest quality of care. This will also cause a lot of the QMEs to drop off. Have you seen our stats? How many of us are still around? And if you look at the numbers of new evaluators they are not as robust as before.

For psychologists, we need a multitude of hours to conduct a clinical interview appropriately because the injury can't be seen on an MRI. You have to do your do diligence and substantiate facts, address non-industrial factors such as developmental history, etc. So it's predictable that the facts are not going to be properly flushed out, thus leading to a report that is not as substantial.

For neuropsychologists, this time is even more expanded given the assessments that we use. Assessing someone's brain takes a lot of time and interpretation of the data that we collect is on another level. I think we need to increase our fee schedule, not reduce it. We should prioritize being able to provide the quality of work that we all want to submit.

All of us take pride in what we do. If we can't do it well, we won't do it at all.

Jodi Bolduc, Owner July 10, 2020
Mainly Transcription

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Joan Mavrinac, MD, MPH July 10, 2020

I am medical doctor with many years of experience who has contemplated participating as a Panel Qualified Medical Evaluator here in California in Workers' Compensation. However, I have been alerted to the idea of the proposed medical-legal fee schedule, along with the history of Workers' Compensation.

I would find the fee schedule to be unacceptable. I need to be able to evaluate a patient

appropriately, do my physical examination, lab testing, and look at the records. Sometimes I need to do medical research to check what would be the most up-to-date in terms of opinions, particularly in complex cases.

As I see this proposal, it appears that it is advantageous to those who would be paying me. It does not appear to be advantageous to the patients nor to the doctor, who has years of experience and much expertise.

I would feel devalued with this proposal, and it would in no way attract me to evaluating patients under such a system. I have experienced working with COVID patients and would not see that this system would be useful in assisting with the claims, which I expect will, unfortunately, shortly be numerous.

I thought it important to share my perspective, given that I am not a part of the system yet. I am not going to join the system under these circumstances.

Diane J. Weiss, MD, MPH
Diplomate, American Board of Psychiatry and Neurology
Assistant Clinical Professor
UCLA School of Medicine
Department of Psychiatry

July 10, 2020

I have worked within the field of Workers' Compensation in the State of California since 1988, having done so as a treating psychiatrist; as an evaluator for the applicant; as an evaluator for the defendant; and as a QME, IME, PQME and AME. As such, it would be impossible to over-emphasize my grave concerns regarding proposed changes to the current fee schedule.

In California, with today's complex, overburdened and largely antiquated Workers' Compensation system, many injured workers already wait several years to resolve their claims, leaving them to exist in limbo. This is particularly true in the majority of those cases with claims of psychiatric injury.

The human psyche is infinitely complex, and every experience affects the psyche. It is essential to a obtain a thorough and careful lifetime history in order to consider not just the diagnosis, but the timing, causation and/or apportionment of an applicant's injury.

An individual has already developed a unique personality and coping style prior to the start of their employment, which is pivotal to how they live in the world. For example, a person with a histrionic personality may experience employment events and interpersonal relations through a much different lens and have many physical symptoms, where it would be crucial to consider such a pre- industrial, non-industrial

condition when determining the how/when/why of their injury and subsequent claim.

Per Labor Code 5307.6, doctors should receive "…fees which provide remuneration to physicians performing medical-legal evaluations at a level equivalent to that provided to physicians for reasonably comparable work, and which additionally recognizes the relative complexity of various types of evaluations, the amount of time spent by the physician in direct contact with the patient, and the need to prepare a written report."

A psychiatrist cannot be constricted by unrealistic regulations and still provide the substantial medical evidence within the realm of reasonable medical probability that is mandated by the Workers' Compensation system in the State of California.

A comprehensive psychiatric evaluation is an inherently complex and detailed undertaking, even more so given the necessity of applying multiple legal cases and concepts in producing the medical-legal report for an injured worker. It is not possible to comply with the needs of this current system of Workers' Comp without spending a great amount of time and thought. Working in the system for over 30 years, I know that in the last ten years it is an extremely rare, exceptional psychiatric claim, which, in any way, would be simple.

The proposals made for ML-204 and ML-205 are positive changes. I appreciate that they acknowledged the expertise needed to work with such necessary complexities by paying AMEs and QMEs for time spent.

However, under the proposed fee schedule, with psychiatrists' time and processes constrained by cookie- cutter regulations and insufficient flat rates (rates which equate a complex psychiatric evaluation with a physical examination for a one-body part injury on just one specific date), doctors are left in an untenable, unacceptable position. As a psychiatrist, I would have no options other than to either provide an inferior, incomplete report which would serve neither the injured worker (i.e. providing substantial medical evidence to settle the case), or **leaving the QME system entirely.**

The consequences of such a schedule, whether intended or not, would include fewer AMEs and QMEs in the Workers' Compensation system, at a time when it is already understaffed and stretched too thin. **Moreover, I fully expect that the coming months will lead to a sharp increase in psych claims due to COVID-19 and its many serious and complex sequelae, including rampant Posttraumatic Stress Disorder. The system must endeavor not only to retain and fairly compensate its current QMEs and AMEs, but also to attract new talent.**

On its website, in the first sentence on its home page, the Department of Industrial Relations provides a most salient explanation of its reason for existing: "*Workers' Compensation benefits are designed to provide you with the medical treatment you need to recover from your work related injury or illness, partially replace the wages you lose while you are recovering, and help you return to work*."

Injured workers are not well served by a backlogged system with too few AMEs and QMEs. Instead, they suffer compounded difficulties when their case cannot reach settlement in any sort of a timely fashion.

In June of 2019, Work Comp Central reported that "Profitability Since SB 863" was "Unprecedented." Despite the latter, in July of 2019, with the issuance of the "WCIRB 2019 State of the System Report," it was indicated that the cost of medical-legal evaluations remained the same from 2013 to 2018, with medical-legal evaluations making up only 6% of the distribution of what was designated as "Paid Medical Benefits."

Nonetheless, compensation for AMEs and QMEs stagnated in 2006, and has remained so, without even so much as a cost of living adjustment (COLA) in 14 years.

In fact, the proposed fee schedule would slash those 2006 rates of compensation, even while the role of a psychiatrist in Workers' Compensation is ever more intricate, with doctors required to be near-experts in legal cases (i.e., the Rolda, Benson and Kite decisions, etc.).

In order to justify whether or not, and/or how, a particular legal concept would apply to a given psychiatric claim, the bare minimum of two hours' time spent face-to- face is not adequate. The time needed to examine a patient varies greatly in psychiatry, where there is no way to know beforehand how long would be required. In fact, it only begins to be apparent how long may be necessary, in order for opinions to be based upon substantial medical evidence, once the evaluation has begun.

The psyche is incredibly complex, and personality characteristics and trends are highly individual and impactful in a patient claiming a psychiatric injury. Many applicants have had multiple employers with overlapping time periods related to the same body parts, involving injuries of both a specific and a continuous trauma nature, and, as cannot be overemphasized, everything affects the psyche and must be considered. Yet the entire concept of complexity is ignored by this unacceptable fee schedule; in fact, the complexity factors have been removed entirely from this proposal.

There are important questions which must be considered. Did the AME in Orthopedics address all of the body parts claimed? If there is a history of multiple Workers'

Compensation claims, have the injuries been similar across different cases and employers? Have the claims been amended?

In terms of Benson, for example, in recent depositions I have been asked to produce supplemental reports specifying what specific injuries, versus what continuous trauma injuries, involve what percentage of the claimed mental disorder(s) pertaining to a particular patient. However, applicants are generally unable to remember time periods, let alone specific dates, and often do not have the psychological insight to assist in sorting out these differences. It is only after reviewing every page of each medical record with a fine-tooth comb that one can determine whether the provided medical records have been helpful in this regard, either.

It is important to clarify for the proposers of this fee schedule why I, a psychiatrist, find it so unacceptable. With this flat-rate schedule, a psychiatrist would be paid the same rate no matter how many hours were necessary to examine the injured worker face-to-face, no matter how many employers a claimant may have had, no matter how many injuries there were across various specialties, and no matter how many years were involved.

There are other aspects of a new fee schedule which need to be implemented. Cover letters should be sent at least 15 working days prior to the scheduled evaluation, and should be required to state the exact number of pages of medical records being provided for physician review.

Records should be sent to the QME at least 15 working days prior to the scheduled evaluation (not right up until the report is issued, as proposed). If not, the QME should have the same number of days the records were late in order to submit their report. This was agreed upon in stakeholder meetings; however, like many other things, it did not make it onto the fee schedule as was negotiated.

Thousands of pages of medical records can be sent for review, where they are not provided in any sort of chronological order and contain multiple duplications, blank pages, missing pages, personnel reports, and payment receipts. All of this information must be carefully looked at and organized into a usable fashion prior to the physician reviewing the individual documents. This alone can take hours.

The proposed idea that a doctor can careful read and review 100 pages of medical records per hour is entirely unrealistic, particularly related to a psychiatric claim of injury. As noted, everything affects the psyche and must be considered.

DOCTORS CANNOT BE ASKED TO ORGANIZE MEDICAL RECORDS IN A USABLE, CHRONOLOGICAL ORDER, REMOVING THE EXCESSIVE DUPLICATIONS, AND THEN COUNTING THE PAGES OF RECORDS, WITHOUT BEING FAIRLY COMPENSATED FOR THEIR TIME. THIS WOULD PLACE AN

UNDUE AND UNCOMPENSATED BURDEN UPON QMES AND AMES. RECORDS SHOULD BE PROVIDED TO THE QME/AME BY THE INSURANCE CARRIER, WHERE THEY ARE ALREADY ORGANIZED (WITH DUPLICATES REMOVED). THIS ALONE WOULD SUBSTANTIALLY REDUCE AN EVALUATOR'S BILLABLE HOURS, THEREBY SAVING THE CARRIERS MONEY

In short, despite all of the latter, doctors are now expected to do more, and do better, in less time, for rates that do not begin to acknowledge or respect the extraordinarily complex nature of these cases, or the expertise and experience of psychiatrists. To further add insult to injury, all of this should be done with one hand tied behind our backs, while under the threat of disciplinary action and/or nonpayment if every single expectation is not met.

The Workers' Compensation system cannot operate with any assumption that the doctors, who are signing under penalty of perjury, are not to be trusted or believed.

If psychiatrists are not fairly compensated for each hour worked, and, instead, are only able to bill arbitrary flat rates for work requiring tremendous amounts of time, energy and expertise, I can see no realistic way for quality AMEs and QMEs to perform thorough evaluations or produce usable reports. There would not be a way to produce substantial medical evidence within the realm of reasonable medical probability.

Under the proposed fee schedule, what would be the only option would be to provide a report of subpar quality, certainly not one that would be able to be used in this medical-legal context.

I would understand that I am not alone in terms of acknowledging the necessity to produce a thorough report of an appropriate medical-legal evaluation, with a review of medical records, for an injured worker, which is complex. Other medical specialists, such as internists, neurologists, as well as orthopedic surgeons, certainly have such cases.

I cannot speak for others, but it would be inadvisable, and virtually impossible, for the undersigned to continue my participation in Workers' Compensation in the State of California under the circumstances of this newly proposed medical-legal fee schedule. Reimbursement rates should be increased (not decreased), with an automatic cost-of-living (COLA) adjustment.

I very much appreciate this opportunity to share my perspective and my concerns. If I can offer further assistance, please do not hesitate to contact me at my office.

Matthew Steiner, MD, ABPN, ABAM
President/CEO Expedient Medicolegal Services

July 10, 2020

I direct a multispecialty group of 40 evaluators (QME, AME, and Expert Witnesses); this is the context from which my comments emanate.

I have read most of the comments posted to the forum thus far and I certainly don't envy the decision-makers with regard to how to pore through these comments to come up with the conclusion as to how to rectify varying concerns. From an operational perspective, the question to be answered is: *what fee schedule will provide an adequate supply of experienced evaluators to perform the work needed to service and resolve the claims of California's injured workers today and in the future*? If it were my task to choose a billing code to compensate these evaluators, this is the question I would try to answer. I would strive to pick a solution that is *as permanent as possible*. I'm sure everyone agrees that getting it *right* is certainly a priority for all. This should be our common ground.

There is a backdrop to be considered to the question posed above. The number of QMEs is dwindling (3500□~2200 or less) as the number of panel requests are increasing over the same period (~70K-150K annually). There is already a shortage of QMEs, and some specialties exhibit greater shortages than others. Designing a *one-size-fits-all* flat fee solution on this backdrop is difficult, arguably impossible.

Complaints can roughly be broken down into two categories concerning the current proposal; *general complaints* that apply to all QMEs, and *specialty-specific complaints*. The *general complaints* fall into 2 categories; complaints involving *ambiguity* (e.g., how are pages to be defined and counted), and complaints involving *compensation* (e.g., all pages over the flat rate should have a single compensation rate of $X.XX per page).

As a psychiatrist regarding specialty-specific complaints, I think the part of the current billing proposal that places it at its greatest jeopardy of becoming a failure is its effect on mental health evaluators. Other specialties' specific complaints also have merit (oncology, toxicology, internal medicine, etc.), however, mental health evaluators are the biggest losers in the current proposal. I'm hoping this fact does not get lost since I believe it to have the greatest impact upon the issue of success vs. failure of the new billing code and the permanence of the *fix* that appears to be desired by most of the stakeholders. I am also concerned that there is a perception in the DWC and with the stakeholders that there is an adequate number of mental health evaluators. I have heard it said that there is a large number of mental health evaluators performing relatively few evaluations - or at least this is the perception. It is also a fact that most, if not all, mental health evaluators view this as a significant pay cut because the vast majority of all the hours put in by mental health evaluators to date have been compensated hourly, as cases are most often billed as

ML104; this is not the case for other specialties.

I'm hoping that the DWC and other stakeholders do not simply believe that there are enough mental health evaluators and that enough will remain after this pay cut is put into place. Many of the best and most experienced mental health evaluators will certainly leave if improvements specific to mental health evaluators are not enacted. The remaining mental health evaluators may choose to spend less time on their reporting because they perceive a pay cut; this is a supposition but I believe a fair one. Some mental health evaluators may leave simply because they do not want to reduce the quality of their work or risk not being in compliance with what is mandated to perform a comprehensive psychiatric disability evaluation (details covered below). Since there are fewer psychiatry QMEs in comparison to psychologist QMEs, attrition of psychiatric QMEs could cause significant difficulty in obtaining panels with a psychiatrist if that is the preference of the parties. The average compensation offered to a psychiatrist working outside the DWC may also become a factor leading to the attrition of psychiatrists. Although every decision about employment is not about authorization for every doctor, this reality should not be ignored.

The current proposal is swimming upstream against the tide of QMEs leaving the system and an increasing number of panel requests; demand for QME services is increasing while supply is dwindling. In speaking with many QMEs in various specialties, it is clear that some, or many, evaluators (e.g. some orthopedists) are close to satisfied while I personally have spoken to zero mental health evaluators who are in the slightest bit pleased with the current proposal. This, in my view, is the Achilles' heel of the current proposal.

Please consider: there is currently an incredible demand for the services of mental health professionals outside of the California Workers Compensation system in general, both on the clinical side and the medical-legal side. Talk to any mental health professional (psychologist, psychiatrist, LCSW, MSW, etc.) and they will tell you that they are getting hounded by recruiters and receiving excellent job offers with much higher compensation compared with even one year ago because the supply of mental health professionals is being outstripped by increasing demand for their services. This is partially stemming from the coronavirus pandemic. Current reports are suggesting a doubling of the rate of clinically significant mental health problems in Americans (~prevalence of 15-20%□~25-30%); that problem is not currently getting better. There is no shortage of current articles on the topic of increasing substance abuse, depression, anxiety, and considerable worry about the likelihood of increasing suicide rates related to the long-term fallout of the coronavirus pandemic. Telehealth jobs are being offered with better compensation rates than you could previously receive for in-person work. If mental health QMEs are perceiving a pay cut from the new billing schedule, many will simply choose not to go back to work; they will choose other options that are better compensated and perhaps more desirable. From reading the comments, it is quite clear that mental health evaluators perceive that the current proposal is a pay cut and their services are undervalued by the current proposal. Many have stated that they will surrender their QME certification and choose to work elsewhere. Many of these intentions will come to pass if the current proposal is not modified.

This gets back to the initial point, which is that this fee schedule must consider supply and demand issues. These issues are quantifiable, objective, and at least somewhat predictable, now and in the immediate future. There is a certain level of compensation that will supply the system with the experienced QME evaluators it needs. The system cannot function adequately without a necessary supply of evaluators in all specialties, and supplying the system adequately should certainly be a goal of all the stakeholders. A one-size-fits-all billing schedule will not result in equal supply in specific specialties. The work that is asked of each specialty is not identical, so a flat rate is an imperfect fit in this environment. The current proposal is lopsided because it is perceived as a pay increase for certain specialties and a pay reduction for specialties that previously utilized the ML104 billing code most often (e.g., psychiatry and psychology).

Many QMEs of other specialties, and perhaps the stakeholders, do not understand why such a large modifier should apply to mental health evaluations. Without understanding the background of what psychiatric and psychological evaluators are asked to do (that differs from other specialties), this an understandable and justifiable reaction. I think it's important for the mental health QME community to educate and explain why these changes are necessary.

The previous billing code recognized the complexity of mental health evaluations by providing psychiatric evaluations their own complexity factor; they are the only specialty with their own complexity factor. Psychiatric and psychological evaluators are the only evaluators that are allowed to reschedule an appointment if they do not receive medical records according to the current regulations (https://www.dir.ca.gov/t8/34.html).

> (g) Failure to receive relevant medical records, as provided in section 35 of Title 8 of the California Code of Regulations and section 4062.3 of the Labor Code, prior to a scheduled appointment shall not constitute good cause under this section for the evaluator to cancel the appointment, **unless the evaluator is a psychiatrist or psychologist** performing an evaluation regarding a disputed injury to the psyche who states in the evaluation report that receipt of relevant medical records prior to the evaluation was necessary to conduct a full and fair evaluation.

The current system recognizes the unique importance of making sure that mental health evaluators can review the records when they are performing their evaluations.

These are some of the reasons why psychiatrists and psychologists bill at an ML104 rate: they earn a complexity factor for their specialty (1 factor); they almost always have records because it doesn't make much sense for them to examine without them (2 factors); they are almost always asked to address causation or causation is in dispute (3 factors); and, as will be seen below, there are mandates on what questions they must ask, which makes their evaluations extremely lengthy. As will be seen below, if psychiatric and psychological QMEs are following the California Code of Regulations, their examinations will certainly be well over an hour, most often 2 hours in duration (4 factors) to meet all the standards outlined by the DWC for the assessment of psychiatric disability.

Regarding proof offered for the time required to perform an adequate psychiatric and psychological QME evaluation, please reference:

California Code of Regulations, Title 8, Section 43 states:
(https://www.dir.ca.gov/t8/43.html)

> "(a) For all claims arising before January 1, 2005, not subject to section 43(b), the method of measuring the psychiatric elements of a disability shall be as Set forth below in the "Psychiatric Protocols" as adopted by the Industrial Medical Council on July 16, 1992, and amended on March 18 and October 25, 1993. The full text of this document is available at no charge on the web at www.dir.ca.gov/IMC/guidelines.html or by calling the Medical Unit at 1-800-794-6900.

If you click on "Psychiatric Protocols" it will take you to a 15-page document titled "*Method of Measurement of Psychiatric Disability.*" As a matter of education, anyone who considers a 3 times multiplier for a psychiatric QME absurd should read this document. Once again, this document is codified in the California Code of Regulations, Title 8, Section 43. If the psychiatric multiplier is not considerably improved from the current proposal, then this part of the California Code of Regulations requires modification (but of course I defer that to attorneys). The bottom line is that too much is being asked and too little offered to remain in compliance with this code.

The document referenced above under psychiatric protocols is a detailed outline that is written into the California Code of Regulations to establish standardization of the assessment of psychiatric disability. This is certainly part of the evidence for the complexity of psychiatric and psychological evaluations. If this document is followed, which it should be in all cases, the history and procedure contained in this document can certainly not be accomplished thoroughly in a one hour face-to- face evaluation under any circumstances; in my opinion, it's impossible (and this may well be the reason for the minimum duration of one hour required).

In my experience and in the experience of a vast majority of psychiatric and psychological QMEs, the process of complying with this document takes at least 2 hours. If the work is done in less than 2 hours then it is either cursory or noncompliant. There are regulations that deal with consent, required paperwork, and other matters that take additional time. Psychiatric and psychological evaluators must establish rapport to form a relationship that reveals factual and relevant information from the answers given by the injured worker; this takes time. The answers of the injured worker are couched in their credibility which must be assessed. Most often, the injured worker is describing extremely long interpersonal conflicts (discrimination, work stress, harassment, personnel actions, etc.) that have taken place over many years and the mental health QME must record those and then synthesize an opinion filtered through an understanding of the legal codes to present a comprehensible and workable assessment to the various parties. It takes time to establish rapport and improve the quality and accuracy of the assessment. For any other specialty, the AMA

guides provide ratings based on range of motion or other measurements that are quantifiable; this is not the case with psychiatric and psychological evaluations.

Additionally, over 50% of the time, mental health assessments require speaking through an interpreter. Due to the volume of questions that psychiatric and psychological QMEs are mandated to ask, this adds a great deal of time and complexity to the evaluation. Cultural differences also come into play. The experience and knowledge of the evaluator must also heavily consider culture in terms of the responses of the injured worker. Of course, I understand other specialties also have to consider culture in their assessments in terms of what the injured worker reports. There is well- established literature with regard to the typical symptoms reported by different cultures and how different cultures respond to particular words used by an evaluator. While the use of an interpreter makes any evaluation more difficult regardless of specialty, this is especially true with mental health evaluations due to the length of the evaluation. In many cases, the proper use of an interpreter can almost double the length of a face-to-face evaluation. This is also true of depositions, which attorneys themselves can attest to. The reason for belaboring this point is to give an understanding as to why mental health evaluators may simply decide to no longer do this type of work if the compensation is not adequate and on par with compensation prior to this proposal.

Further evidence comes from the regulations, which recognize the complexity of psychiatric and psychological evaluations by stating that they must be *a minimum of 60 minutes*; *3 times longer* than other specialties which need to be 20 minutes at a minimum (link below for musculoskeletal evaluations).

https://www.dir.ca.gov/t8/49_2.html#:~:text=%C2%A749.2.&text=A%20medical%20evaluation

%20concerning%20a,time%20for%20an%20uncomplicated%20evaluation.

More examination time requires more time to write and formulate medical opinions. General medical records more frequently include references to mental health concerns and vice versa. For example, it is infrequent that psychiatric records reveal orthopedic concerns to orthopedists. It is more common psychiatric and psychological concerns flow from physical problems than vice versa. The system recognizes this and often chooses to refer to qualified medical evaluators in the field of psychiatry and psychology *after* an applicant has seen evaluators in other specialties. The reason for this is that it doesn't make much sense to declare someone as permanent and stationary on a psychiatric basis if they are going to receive a shoulder surgery next month; their mental condition more often flows from their physical condition.

The psychiatric exam is mandated to be 3 times longer than a musculoskeletal examination, but the modifier provides only a *50%* improvement in the flat rate. One could argue that an examination that is mandated to be 3 times the length should be compensated at 3 times the flat rate; this arrives at the recommended CSIMS multiplier of 3.0.

CSIMS has presented the following data that I believe to be factual. Medical-legal fees have not increased as a proportion of the overall budget between 2013-2018. Insurers' profits have increased significantly over that period. QMEs have not been given a raise or cost-of-living adjustment in almost 15 years. Mental health QMEs represent a relatively small portion of the overall number of panel requests annually; something on the order of ~10% according to CSIMS leadership. *Accordingly, any modification to the proposed billing code, such as creating a 3X multiplier to psychiatric and psychological QME evaluations, will have a minimal effect on total medical-legal fees.* I hope this response has served to educate and justify that multiplier.

Rolling the dice and providing a perceived pay cut will drive out the most experienced mental health evaluators and risk creating a crisis related to the unavailability of experienced psychiatric and psychological QMEs in light of the other opportunities that the current market presents. These are not theoretical concerns - these are the stated intentions of many of my mental health colleagues in response to this proposal.

In addition to what I have presented here, I also support the other general concerns applicable to all QMEs outlined by the response given by CSIMS (record review compensation rate, elimination of ambiguity in various aspects of the proposal, application of modifiers for other subspecialties, etc). I will not enumerate those, but I am wholly supportive.

It has been related to the CSIMS community by Dr. Steven Feinberg that the DWC simply proposed a billing schedule and it is open to significant changes. *I hope sincerely that one of those changes squarely and fairly addresses the psychiatric and psychological multiplier.* If a flat rate billing schedule is eventually adopted, I encourage the DWC to adopt a schedule that will achieve the goals necessary for California's injured workers.

Carlos L. Rodriquez, MD July 10, 2020
Psychiatrist

I am writing this letter to oppose the proposal to alter the regulations for the medical legal fee schedule. There are multiple issues that make this alternative proposal a negative for all psychiatrist/psychologist. Psychiatric evaluations are expected to consider the entire physical system, including physical injuries, medical conditions (both nonindustrial and industrial) along with the psychiatric condition in order to formulate an opinion/conclusions that are acceptable by all parties. This does require a significant amount of time to do. The current billing code recognizes this by allowing a single complexity factor to all psych evaluations at baseline. Psychiatric and psychological evaluations are a minimum of 60 minutes in duration when most other evaluations are only 20 minutes. More examination time equates to more time required to formulate and

compose conclusions. Considering this complexity, a minimum of a 3X modifier must be applied to all psychiatric/psychological reporting including initial evaluations, reevaluation than supplementals. Additionally, the fee for reviewing a page of medical records should be $3 regardless of how many pages are reviewed. It does not make sense that reviewing page 1000 of a medical record should be reimbursed at a lower rate than page 10. The fee schedule should include an automatic annual COLA (cost-of-living adjustment). It is very concerning that medical legal evaluators are still being paid the same amount as they were 15 years ago, without any cost-of-living adjustment in all of that time.

Being expected to conduct such a complex and detailed evaluation for even less pay would force me to reconsider whether it is even worth it to continue conducting evaluations. I could not continue to conduct thorough and complete psychiatric evaluations that would satisfy all parties (attorneys, trier of fact, applicants) for an even smaller reimbursement then the current fee schedule.

I agree with CSIMS in their response to the current proposal and find it very disturbing that the agreements made in the stakeholder meeting were not followed.

Roger Karlsson July 10, 2020

I wish to address a number of issues regarding the proposed new fee schedule for QMEs under §9795.

First, psychiatric and psychological evaluations are by definition more complex and take a great deal more time in most cases. The current billing code recognizes this by allowing a single complexity factor to all psych evaluations at baseline.

Second, psychiatric and psychological evaluations are a minimum of 60 minutes in duration when most other evaluations are only 20 minutes. More examination time equates to more time required to formulate and compose conclusions. Also, more examination time gives the evaluator a chance to develop rapport with the patients, which will make them open up more about their psychiatric and psychological history and help us make more accurate conclusions.

Thirdly, the current proposal damages psychiatric and psychological evaluators who have been performing complex and lengthy evaluations that will not be reimbursed adequately under the current proposal. This will likely result in more attrition of mental health evaluators which will adversely impact the patients.

The lowering of the fees would make me less interested in performing QME evaluations in the future.

Jerry O' Day July 10, 2020

I am a Psychologist and QME for approximately 3 years. I value the work and respect that the work I do is important in resolving legal matters affecting employees. I am honored to do this work.

Respectfully, the proposed regulations are dangerous as they reduce the hourly actual fee for psychologist's or psychiatrist's rate dramatically in order to meet guidelines that required reports of often more than 100 pages. The time taken can be extensive approaching 30 hours or more of writing and report preparation. The report fee would work out to $75 and hour or less. This is a tremendous reduction in hourly rate. Why? This a reason for many skilled Psychologist to rethink the effort needed to continue providing services. This fee they would then be split with a vendor and results in up to 50% less. You are expecting then a skilled Psychologist and Psychiatrist to complete a report approaching 100 pages and 30 hours for less than $40 per hour. Why would you think Psychologists and Psychiatrists would work for this amount considering their other options? This would mean many fewer skilled clinician to complete QME's in area of Psychology. I do not believe you want fewer clinicians to be able to help employees to move one with their lives and not remained bogged down in waiting.

I also consider that having opposing lawyers be able to re-question clinician reports with required responses in writing which may take many pages and hours without any reason beside their opinion that it was not answered in satisfactory manner in their clients best interst. Clinicians would have to rewrite for no reimbursement. I am sure you could use this as a recruiting point.

I do have questions about section 9795 section d. This section in part douses overhead expense. Nowhere in the remain categories of fees do the regulation describe the method or a rate for which these expenses can billed. What are the rate and method of billing for overhead expenses?

I approve cite the need to update the fee schedule. Thank you for the opportunity to provide comment.

Antonio Villalobos July 10, 2020

I have worked for doctors who do medical-legal evaluations in Workers' Comp for several years, and have more recently been working with a highly experienced and well-

regarded Qualified Medical Examiner and Agreed Medical Examiner in Psychiatry practicing in Southern California.

As proposed, this prohibitive fee schedule would mean that the psychiatrist I work for would be unable to produce the kind of reports needed by Workers' Compensation. Without being fairly compensated for the doctor's time on an hourly basis, like other psychiatrists and psychologists, like the lawyers with whom the doctor works, and like other professionals, the doctor would no longer be able to work as either an AME or as a PQME, and I would be out of a job.

The doctor pointed out Labor Code 5307.6 to me. It's stated that doctors should receive "…fees which provide remuneration to physicians performing medical-legal evaluations at a level equivalent to that provided to physicians for reasonably comparable work, and which additionally recognizes the relative complexity of various types of evaluations, the amount of time spent by the physician in direct contact with the patient, and the need to prepare a written report."

This flat fee schedule is impractical, confusing, open to misrepresentation and misinterpretation. Ultimately, it is unworkable. I would understand that, for psychiatrists, instead of a raise, this would be a major decrease in payment, where the doctor fears having to close the office.

I appreciate the opportunity to comment upon these changes and express my concerns for the far-reaching consequences of this proposal.

Martha Ruiz-Shank, PsyD, QME July 10, 2020
Nest Counseling and Psychological Services

My name is Dr. Martha Ruiz-Shank and in the past year I became a QME. I have read the proposed fee schedule and I find it unfair and inadequate. If the proposed fee schedule takes effect, I would not be able to continue as a QME. The most concerning part is that colleagues have shared the same feeling which means that injured workers in need of psych QMEs will be without treatment for their industrial psych injuries.

Please refer to my following concerns regarding proposed fee schedule:

1. A modifier of 1.5 is not sufficient to compensate a QME in psychology or psychiatry. The modifier should be 3.0. The psychological interview requires a gathering of extensive information far greater than any other specialty. These interviews often take longer than three hours. The information must then be incorporated in a comprehensive report and a lengthy discussion of how each of these factors does or does not play a role in causation and apportionment.

Psych is the only specialty that has a causation threshold of predominance. This requires a much more extensive and detailed discussion for both causation. Psychological reports also frequently require a lengthy discussion of personnel actions and a Rolda analysis, which takes further time.

2. It makes no logical sense that records 1801 and beyond will take less time to review than the first 1800 pages. There should be a flat fee for all pages of $3.25 for all pages reviewed, which is consistent with the proposed new hourly rate of $325 an hour. There also needs to be clear stipulation that double sided pages count as two pages, condensed depositions count as 4 pages, and a standard page size is 8.5x11.
3. Doctors need to receive records before the evaluation in order to perform a comprehensive history gathering. At the very least the cut off should be the day of the evaluation. If we are required to include records received at any time prior to issuing of the report, this is bound to cause delays in reporting and even late reports, which will just complicate the system, causing delays, denied reports, and requests for new panels.
4. A period of 24 months is too long to be considered a re-evaluation. The amount of records and interim information can be extensive and the re-evaluation rate is inadequate for this. The span should be no more than 12 months.
5. There must be a COLA included with the fee schedule so that the rate that QMEs are paid does not rapidly become inadequate, bringing us back to the problems that is occurring now.

I was looking forward to helping injured workers in the realm of psych claims and this proposed fee schedule is disappointing. However, I am hopeful that the DWC takes our concerns strongly into consideration and reaches a fee that is equitable to all parties.

Tyson Chung, PhD, QME July 10, 2020
Licensed Clinical Psychologist
Qualified Medical Examiner

I am writing as a newly appointed QME within the past 2 years. As a psychologist, many of these cases are not simplistic and require a great deal of time and feel that the proposed changes are unacceptable and undermines the quality of work I believe most QME's aspire to produce.

I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is disappointing that DWC has undercut these

levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,800 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

Sue Honor's proposal and the accompanying petition can be found here: https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues, but have been very hesitant to encourage some of my colleagues to consider becoming an injured worker provider. This proposal will be the final straw for many providers, including myself and will unlikely continue at the end of my renewal period. It is unfortunate that it is the injured worker who ultimately suffers as they will no longer have options to obtain good quality care.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Suzanne Honor July 10, 2020
Honor System Consulting

I would like to thank the DWC for allowing the public to comment on the proposed regulations prior to rulemaking. I have reviewed them very carefully and offer the following observations and suggestions:

Regulation 9793

Paragraphs (c), (g), (h) and (m) should be revised to include guidance as to when it is

appropriate for the Primary Treating Physician to be paid under this fee schedule. Alternatively, a separate paragraph identifying when PTPs may be paid under this schedule should be written and cross referenced in the other regulations. This has been an area of constant payment disputes and scrutiny by the DWC which can lead to disciplinary actions. There have been many interpretations of the regulations in light of Labor Codes 4060, 4061 and 4062 as to whether or not PTP's can ever perform a medical-legal evaluation. The regulated public needs DWC to revise the regulations to clearly and concisely identify when the PTP is entitled to be paid under this schedule to help reduce the friction.

Paragraph (h) "Medical Legal Expense": Should include copy services in conjunction with the medical-legal evaluation and interpreter services in conjunction with the medical-legal evaluation.

Paragraph (j) "Medical Research": As this is no longer an element used in determining the level of payment, this paragraph is unnecessary.

Paragraph (l) "Reports and documents required by the administrative director": This definition should not include the correspondence received by the physician by the parties. These are the documents that the medical-legal provider must send along with the billing in order to be paid per regulation 9794 (b). The parties are required to exchange any correspondence that is being sent to the medical-legal evaluator anyway under other rules, particularly Labor Code 4062.3 (e) and (f). Requiring the medical-legal physician to submit correspondence along with the bill places an undue burden on the provider by wasting time and resources.

Paragraph (m) "Supplemental medical-legal evaluation": This section should specify that there must be a written request from one of the parties, the WCAB or the AD.

Paragraph (n) "Record Review": A page should be the equivalent of an 81/2 x 11 sheet of paper. Including 81/2 by 14 legal paper is adding approximately 25% more to the page being reviewed and should therefore be considered to be 1.25 pages for purposes of counting pages.

Recommended additions to 9793:

I recommend adding the DWC include a definition of a cover letter or advocacy letter and indicate what the required elements of such a letter should be. Included in this letter would be the number of pages of medical records being provided to the medical-legal evaluator for review.

Regulation 9794

Paragraph (a) (1): Copy services and interpreters should be included within this

paragraph and references made to the Copy Service Fee Schedule (regs 9980 - 9983) and the Interpreter Fee Schedule (regs 9795.1- 9795.4).

A provision should be added to this regulation allowing medical-legal providers to bill electronically and indicating that electronic bills must follow the Electronic Billing Rules in the Medical Billing and Payment Companion Guide.

Electronic Service . All medical-legal reports, Appointment Notification Forms, and invoices, may be served upon the parties electronically by the physician. All cover letters, medical records, and other information, may be served upon the physician electronically by the parties.

Notices.

A. The parties may provide electronic notice to physicians of all cancellations or rescheduling of evaluations within three (3) business days of such cancellation or rescheduling.

B. All written objections to medical-legal evaluations must be copied to the physician and served by US mail or other delivery service, and electronically.

Regulation 9795

Paragraph (c):

ML 200. *Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation.* There are two components of a missed appointment - the time set aside by the physician for the appointment and the time spent reviewing records. The proposed fee combines the two by including 200 pages of record review and the production of a record review report in the $503.75 fee. This is unreasonable. The intention of the regulated partes was to pay separately for the missed appointment time and the record review if it was performed. $503.75 might be sufficient for the appointment portion, but should not include any pages of record review. Record review should be completely separate. A minimum of an additional $600.00 for the first 200 pages reviewed should be added. After 200 pages, the rest of the proposal, although still too low in my opinion, would apply. I think that all pages should be at the $3.00 per page rate with no reduction after 2000 pages. There is no valid justification for reducing the rate for reviewing more pages.

ML 201. *Comprehensive Medical-Legal Evaluation.* All records reviewed above the first 200 pages should be paid at the $3.00 per page rate. There is no valid justification for reducing the rate for reviewing more pages.

Ml 202. *Follow-up Medical-Legal Evaluation.* All records reviewed above the first 50

pages should be paid at the $3.00 per page rate. There is no valid justification for reducing the rate for reviewing more pages.

ML 203. *Fees for Supplemental Medical-Legal Evaluations.* Requests for these reports should be in writing. All records reviewed above the first 50 pages should be paid at the $3.00 per page rate. There is no valid justification for reducing the rate for reviewing more pages.

ML 204. *Fees for Medical-Legal Testimony.* The minimum two hour fee should be paid in advance of the scheduled deposition. This reflects the standard for deposition fee payment in civil court. Additionally, the minimum two hour fee should be paid if the deposition is cancelled within the 8 days specified in the proposed regulation.

Modifiers -94, -96, -97 and -98. The increases proposed for these modifiers should apply to all services performed by those providers, not just ML 201 or 202.

Recommended additions to 9795

COLA adjustment. Commencing on January 1, 2021, and on January 1 of each year thereafter, the minimum fees and hourly rates, shall each be increased to reflect a cost of living adjustment ("COLA") based on the annual Consumer Price Index, or 4%, whichever is greater.

Additional payment for disorganized records. Organizing every 100 pages of medical records or any portion thereof that are not in compliance with the regulation 35 (c).

Additional payment for complex apportionment or extensive permanent impairment ratings. Complex apportionment is defined as: A discussion of apportionment of disability when determination of this issue requires the physician to evaluate (1) the injured worker's employment by three or more employers, where the employment by those employers contributed to the disability, (2) more than two injuries to the same body system or body region as delineated in the AMA Guides, or (3) more than one injuries involving two or more body systems or body regions as delineated in the AMA Guides, but only if the physician finds the injured worker to be medically permanent and stationary or to have reached maximum medical improvement. Extensive permanent impairment ratings is defined as: Providing an impairment rating for each additional body system or region in excess of the first body system or region as delineated in the AMA Guides or in excess of the first limb.

General Comments:

The pricing indicated in the proposed regulations is lower than what was discussed at the Stakeholder Meetings and appears to be too low to attract and retain QMEs in the

workers' compensation system. The proposed regulations put all of the burden on the medical-provider to keep track of the number of pages sent for review and puts no burden on the parties to organize or keep track of what they have sent over. There is nothing in the regulations to hold the parties accountable, but there are potential disciplinary actions that can be levied against providers for not following the rules. This appears to be a bit one sided. In the absence of COLA increases, there is nothing to prevent DWC from waiting another 14 years before revising the fee schedule again. Although physicians may be willing to accept lower payment initially, it would be expected that regularly scheduled increases would be provided to help bring rates up to a competitive level over time. As proposed, medical-legal providers in California will be reimbursed significantly less then similarly qualified physicians providing equivalent reports in other states.

Again, thank you for allowing the public to comment on the proposed regulations. I hope you will take these comments into consideration when finalizing the regulations.

Norman A. Linder, MD July 10, 2020

Please utilize Suzanne Honor-Vangerov's medical legal fee schedule for more appropriate reimbursement of QME physicians for their services and expenses regarding the QME process. As you know, running and operating a QME medical practice is much more time consuming and complex than a standard medical practice. The DWC's alternative proposal would not adequately cover practice expense and would result in more physicians abandoning the QME certification.

I strongly recommend you use Suzanne Honor-Vangerov's medical legal fee schedule.

Virginia Giritlian July 10, 2020

I have worked for doctors who do medical-legal evaluations in Workers' Comp for several years, and have more recently been working with a highly experienced and well-regarded Qualified Medical Examiner and Agreed Medical Examiner in Psychiatry practicing in Southern California.

As proposed, this prohibitive fee schedule would mean that the psychiatrist I work for would be unable to produce the kind of reports needed by Workers' Compensation. Without being fairly compensated for the doctor's time on an hourly basis, like other psychiatrists and psychologists, like the lawyers with whom the doctor works, and like

other professionals, the doctor would no longer be able to work as either an AME or as a PQME, and I would be out of a job.

The doctor pointed out Labor Code 5307.6 to me. It's stated that doctors should receive "…fees which provide remuneration to physicians performing medical-legal evaluations at a level equivalent to that provided to physicians for reasonably comparable work, and which additionally recognizes the relative complexity of various types of evaluations, the amount of time spent by the physician in direct contact with the patient, and the need to prepare a written report."

This flat fee schedule is impractical, confusing, open to misrepresentation and misinterpretation. Ultimately, it is unworkable. I would understand that, for psychiatrists, instead of a raise, this would be a major decrease in payment, where the doctor fears having to close the office.

I appreciate the opportunity to comment upon these changes and express my concerns for the far-reaching consequences of this proposal.

Alberto Lopez July 10, 2020

My name is Alberto Lopez and I am a psychiatrist. I am writing from a strong need to the recently released proposed changes to the QME reinbursement schedule. I have been doing QMEs for over thirty years. As QMES we have had to work with the same fee schedule for over 10 years without even a cost-of-living adjustment. I find the proposed changes very unsatisfactory. In view of the complexity of psychiatric claims the conversion factor for mental health evaluations should be at least three(3x).As the system currently operates we have been losing QMEs and few enter the field in view of the low reinbursement . In addition the mental health evaluations should be allowed remotely, in that a physical exam is not required and we live in perilous time . Many doctors are over 65 as are many examinees.I hope you will re-consider the proposed fee schedule and adjustment to a rate that is more equitable and addresses the need not only of the doctors who do this work but the system as a whole.

Gina Sillo, Psy.D, QME July 10, 2020

The current proposal is especially unfair to those who work the hardest and deliver the most informative work products. Psychiatric and psychological evaluators perform the most complex and lengthy evaluations that under the new proposal will not be reimbursed adequately. This will likely result in attrition of mental health evaluators and

a decline in the quality of reports, ultimately adversely impacting injured workers. The quality of these evaluations are key for injured workers receiving accurate Psychiatric diagnoses and informed treatment recommendations.

The current proposal is imbalanced favoring a raise for certain specialties while issuing a pay cut for others. If the current fee schedule is implemented without changes, I will need to see if I can continue my practice.

The change in reimbursement will likely force me to change the quality of my practice (tests I can utilize) and I will need to make a decision about whether I can deliver a quality work product on the behalf of the injured worker.

I agree with CSIMS in their response to the current proposal. The agreements made in the stakeholder meeting were not followed and should not be walked away from.

Michael Z. Mekjian, PhD July 10, 2020
Qualified Medical Evaluator
Licensed Clinical Psychologist

I am writing to convey my serious concerns about the proposed MLFS revisions now being considered. As a Psychologist, I am significantly troubled by the major cut in compensation for psychological/psychiatric evaluations, when there should be, instead, a COLA increase from 2006. The kind of proposal now being considered only serves to further drive practitioners away from the worker's comp system, and depletes the quality of participating practitioners. Additionally, it is clear that, if this fee schedule is implemented, it would result in a significant decline in the quality of reports being submitted. Based on the DWC's guidelines for what is required to conduct a comprehensive evaluation, and submission of a ratable report that considers all of the complexity factors and meets criteria for substantial medical evidence in a psychological/psychiatric case, the proposed Fee Schedule is far from being fair compensation.

Additionally, because of the complexity of factors involved in conducting a psychological/psychiatric evaluation, the mental health modifier should be increased to 3x. Face-to-face interviews can generally take up to 3-5 hours, and must include comprehensive history taking dating back to childhood events and continuing to the present, in order to comprehensively assess for prior emotional traumas, contributory events, and prior psychiatric treatment – all of which must be taken into consider when determining causation and apportionment.

It is also my opinion that the proposed reimbursement rate for review of records, in reality, is a cut in compensation, and that $2.00 per page is woefully low, and that a reimbursement rate of $3.00/page for **all** pages reviewed should be provided.

Additionally, the interview data and psychological test data collected at the time of the initial evaluation, becomes outdated, and is no longer a reflection of the patient's current mental health status, and should not be utilized to determine the functionality of a patient, nor the degree of therapeutic progress they have made. The standard of care has always been to comprehensively re-evaluate the patient, by obtaining current/relevant data in the form of history taking, review of new relevant medical records, and re-administering psychological testing that is reflective of how the patient is doing now, rather than 12 months ago. This is not a complicated concept to understand, and is a common practice that is the essence of the Standard of Care that we have come to expect, and is required in order to responsibly re-evaluate a patient and provide relevant/current information regarding their MMI status, and subsequent treatment recommendations. Subsequently, any evaluations conducted from the 12 month interval and greater, should be reimbursed at the rate for a comprehensive evaluation. Additionally, a re-evaluation interval of 24 months is a completely unacceptable Standard of Care.

I ask that you please consider these factors when making a final determination about the proposed MLF revisions. This is not solely about reimbursement rates, but is also about maintaining a high level of standards for our California Worker's Compensation System, that will not only result in maintaining a higher level of QME, but also ensure the rights of applicants.

Daniel J. King, Psy.D. July 10, 2020
Qualified Medical Evaluator
Clinical and Forensic Psychologist

I am a QME. If these proposed changes are accepted and go into effect I would probably have to stop doing QME work. Psychiatric QME evaluations are incredibly time intensive, more so than other specialties. It is necessary to explore in depth numerous life stressors, symptoms and treatment throughout the individuals life span. The interview, record review and discussion of opinions needs to be extensive for to have a substantial medical evidence report. The proposed compensation for this work would not justify the time required.

Blanca Cervantes, MD, QME July 10, 2020

It would not be cost effective to continue as a QME if the proposed changes are made to the fee schedule. As it is, QMEs are scarce so this would inevitably adversely affect injured workers and the attorneys attempting to find a QME for their client.

It is pretty obvious that the only parties who benefit from these changes are the insurance companies who lobby persistently for their bottom line. As a state entity, I would hope that the DWC sees that in making these changes it would be favoring the financial bottom line of the insurance companies rather than the interests of the injured workers, who require evaluation by QMEs, followed by the proposed treatment suggested by QMEs. Insurance companies would love nothing more than to make it hard to find a QME, or to have a long wait time to see a QME so that the evaluation is deferred and thus treatment is delayed. Often, injured workers give up in desperation, or endure unnecessary pain and suffering as a result.

A modifier of 1.5 is unacceptable and should be 3.0, which is more in line with the time required. The time to write Psych reports is extensive and interviews are more complicated and require at least two to three hours because a comprehensive history is required per the DWC guidelines. It often requires a description of continuous trauma including numerous specific events. The report also frequently requires a Rolda analysis. The modifier for psych should be 3.0, or 2.5 with additional modifiers of .5 for a Rolda analysis, and .5 for a history of past psych including past psych claims.

If the DWC intends to be consistent with the new RV that is being proposed then the rate for record review should be $3.25 per page. The proposed fee schedule is suggesting $2 a page for records over 1800 pages. At the commonly accepted rate of 100 pages per hour, this works out to be $200 an hour, which is LESS than the current fee schedule rate of $250. This would be a pay cut rather than he described pay increase that this fee schedule calls itself. All pages need to be paid at $3 per page.

Doctors need to receive records before the evaluation in order to perform a comprehensive history gathering. There must be a more adequate deadline regarding receipt of records. If a doctor has plans to complete the report on the 30th day and mail, but on the 29th day receives 1000 additional pages of records, it would be impossible to review and include these records in the report. The proposed time frame is flawed because of this. A reasonable cutoff date would be the date of the evaluation.

A period of 24 months is too long to be considered a re-evaluation. The amount of records and interim information can be extensive and the re-evaluation rate is inadequate for this. The current fee schedule recognizes a nine-month cut off for re-evaluations. This being extended to 24 months is not acceptable. There is too much interim information to be assessed to be paid at the lower re-eval rate beyond 12 months.

Finally, a **COLA needs to be included with the fee schedule so that the rate that QMEs are paid does not rapidly become inadequate.** Any new fee schedule requires a clause that incorporates an automatic annual fee adjustment to keep rates current.

Sean Sterling, Ph.D., ABPP July 10, 2020

As a psychologist QME, I would like to request that you reconsider the proposed fee schedule changes. Psych QME reports are extremely labor intensive. The current fee schedule is just barely sufficient to make the job worth doing (in fact, I cut back my practice from 10 locations to 1 because I didn't feel I was being compensated sufficiently). If the new fee schedule goes through, I feel very confident that experienced QME's, those of us who are willing to put forth sufficient effort to write high quality reports, will remove ourselves from the system. This will lead to dire consequences for injured workers.

Rosabel Young, MD, M.S. Pharm July 10, 2020

The proposed Fee schedule will effectively reward providers who run "mills" of dozens of small cases a day, like carpal tunnels and back pain cases, to the detriment of providers who deal with complex cases, such as Brain and Internal traumatic Injuries.

Eliminating the ML-104 essentially discounts the value of face to face time and increases the value of Record review and report prep time, which are more likely to be falsely inflated.

Face to face time is the only component that can be corroborated by a patient's or interpreter's signature.

Further, Record review time is not accurately estimated by the # of pages of records.

Clearly, the time to review the same # of pages from a Kaiser record for a carpal tunnel or back pain work up, where much of the notes are repetitive, is not the same as reviewing a hospital record after a Traumatic Brain Injury.

The overall reduced value for complex reports will discourage those of us who get the complex cases from staying in the QME system.

As it is, there is a shortage of Neurologists in the community as a whole, and I have been unable to convince any of my practicing colleagues to become QMEs.

If the proposed fee schedule becomes the new fee schedule, it would discourage new QME candidates further and we might face a crisis not being able to process these complex types of claims.

Paul Dratofil, DO July 10, 2020
QME in Psychiatry

I, as a QME in psychiatry, along with most other physicians have some objections to the proposed changes.The time frame for follow-up evaluations is problematic. Many re-evaluations in psychiatry are performed following six months of active treatment in order to determine permanent and stationary status and occur 9-12 months following the initial evaluation. Such a report necessarily includes determinations of apportionment, causation, permanent work restrictions, need for future medical care, etc. Also, interval psychiatric progress and nonindustrial factors are considered. A reduced rate for such a report is unfair at any time and extending the time frame in the regulations to 24 months is particularly unreasonable.

The proposal includes a reduction in the per page fee for review of medical records after 2,000 pages. There is no evidence that reviewing any page after 2,000 is any less of an effort than reviewing any of the first 2,000 pages- the rate should not change after 2,000 pages. Additionally, the burden of counting the pages is placed entirely on the medical examiner and likely to create disputes about reimbursement. The insurers should be responsible for providing an accurate count of all the pages. A standard page size is 8.5 by 11 inches. Legal sized pages should not be reimbursed at the same rate as standard size. An additional charge for organization of records should be allowed if required, otherwise records could essentially be shuffled and the QME left to organize them.

The definition of a missed appointment should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker, the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation.

There should be clear and reasonable limits on when records can be received in order to require them to be included in a report. It should be required that the doctor receive the records at least 2 weeks prior to the evaluation in order for the records to be reviewed and then discussed with the applicant. This is particularly important in psychiatry. In the event of a missed or cancelled evaluation, the review of records should be compensated at the same rate as in other situations. The nature of and

reimbursement for the report associated with such a review absent an interview of the applicant should be specified.

The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. There should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute.

Dale S. Sherman, Ph.D.
Clinical Neuropsychologist
Professor, University of Southern California

July 10, 2020

I am a clinical neuropsychologist who has been practicing for the past 20-25 years, with 15+ of those years as a QME. My primary role is as a clinician a large metropolitan med-surge hospital and private practice, with part-time work as an adjunct professor at the University of Southern California. I do QME evaluations as a small part of my clinical practice as a way to lend support to the DWC system.

As most of you know and will confirm, neuropsychological and psychological assessments are long, complex, and require administration of objective measures to validate patient claims. Psychological and neuropsychological types of injuries are inherently complex requiring attention to detail and sensitivity to multiple issues for appropriate clinical formulation as well as document in the QME report. This takes time and consideration of all relevant facts/issues.

AS SUCH, THE NEW FEE SCHEDULE IS INAPPROPRIATE AND A TRAVESTY TO INJURED WORKERS, EMPLOYERS, AND THE CLINICIANS WHO ARE ATTEMPTING TO ASSIST THEM, IN THE STATE OF CALIFORNIA.

The proposed changes to the medical-legal fee schedule, serious financial compromise/ underfunding, and lack of reimbursement to the evaluator will further compromise the DWC system. This harms the clinician who is attempting to do a proper evaluation and is clearly an irresponsible proposal by the DWC, including ethical violations and obvious conflicts of interest.

Should these changes occur, psychologists and neuropsychologists, particularly those such as myself who are, in earnest, attempting to use their clinical knowledge and years of experience (e.g., not solely a QME evaluator/ practitioner), will abandon their involvement in the DWC system.

I urge the DWC to reconsider their proposed changes and rather than undercut the QWE evaluator and reduce reimbursement, seek to find ways to **support the process with improvements and incentives for involvement, particularly to INCREASE fees**, rather than deter and turn competent clinicians away. Adopting these changes to reimbursement will introduce sufficient hardship to the clinician to deter continuing as a QME and to remain part of the panel process.

Thank you for NOT adopting this proposed fee-schedule.

Benjamin S. Simon, MD July 10, 2020

I am a QME and CSIMS Member. I have learned that CSIMS and other provider groups med with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon the QME stakeholder process.

Unfortunately (but not surprisingly given DWC's demonstrated track record of bias towards insurance company interests and against injured workers and medical providers), DWC violated the stakeholder agreements in order to favor the insurance carriers.

Specifically, DWC made the following changes against the stakeholders' wishes:

	DWC Stakeholder Meetings	**California DWC Proposal**
Reimbursement per page	$3 (starting on page 201)	$3.00 (pages 201 – 2000) **$2.00 (pages 2001+)**
Definition of page	8 ½ x 11"	8 ½ x 11" OR **8 ½ x 14"**
Definition of re-evaluation	9 or 12 months	**24 months**

	DWC Stakeholder Meetings	**California DWC Proposal**
AME Modifier	1.25x and applies to **all services**	1.35x but applies **only to flat fee and not to depositions**
Medical records required to be sent 15 days prior to evaluation	Yes	**No**
Cover letter required to specify number of pages sent to doctor?	Yes	**No**
Automatic Annual COLA Increase?	DWC refused to hear this issue in the stakeholder meetings	**No**

DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page, because this was agreed to.
- Pages should not be legal sized, only standard sized, this seems ridiculous to even have to say.
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months. Things change substantially in 24 months- although I would find 15 months acceptable personally.
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI for Medical Care in California.

- The definition of missed appointment is too narrow and should be expanded to allow for: the injured worker leave prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i).
- The cut-off date for QMEs to include records or sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report.
- The way in which an unreimbursed “remedial supplemental evaluation” is defined is unacceptable and unfair to QMEs. DWC should rename this to “unreimbursed supplemental evaluation” to clarify the intent of this “service.” Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.
- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.
- Neurology and Internal Medicine evaluations should be entitled to 2.0x modifier.

Alireza Esfahane, MD, QME July 10, 2020

I am a QME, and I have been thinking many times about quitting the QME practice. I see only the patients on Sunday because I want I get the minimum number possible of the patients but want to keep the license, and I hope the see fee schedule changes. I want to share my story that repeats for almost half of my patients. I visited a patient a few weeks ago, travel to the office, 55 minutes waiting for the patient to finish the forms,

and spent 2 hours interviewing and exam the patient. Reviewed 2 hours of medical records and working more than 4 hours writing the report for four body parts injury.

Including my travel time, I spent close to 10 hours, and I found the level is ML 2, for total $620 that I have to pay 40% of the amount to other companies for the services, such as rental place, medical assistant, utility, billing and so. I got home with $380 for 10 hours working after-tax about $230. I work in a clinic now, and if I want to do moonlighting in any other place, I can earn at least $1500 for 10 hours.

I have friends doing QME and have the same stories and not happy. Many of us are waiting for positive changes. Many QME doctors will leave the practice if there will be no hope for them.

I urge you to replace this proposal with Sue Honor's plan, which the QME community has already broadly supported.

Anonymous July 10, 2020

The DWC should read this excellent summary by Mr. Julius Young:
http://www.workerscompzone.com/2020/07/10/the-qme-fee-schedule-needs-work/

Here are some examples of problems, based on real life experiences, for not compensating reviewing records based by the hour but by pages:

Deposition attorney: Dr. Easy Evaluation, how come you said the left shoulder injury was attributable to the fall?

Dr. Easy Evaluation: Well, I was reading the records at 100 pages an hour or more and just looking for physical injuries and not thinking about the records.

Deposition attorney: How come Dr. Complicated Evaluation, who is not in your specialty detected it?

Dr. Easy Evaluation: Dr. Complicated Evaluation probably read the records instead of skimming them.

Deposition attorney 2: Dr. Easy Evaluation 2, how come you attributed the serious injuries to the fall at work?

Dr. Easy Evaluation 2: Well, I read the MRI and it was done soon after the fall.

Deposition attorney 2: Dr. Easy Evaluation, 2, did you read the records around that time suggesting that he had a car accident and that his symptoms and number of physical injuries after that accident were greater than after the fall?

Dr. Easy Evaluation 2: Well, I was reading the records at 100 pages an hour or more.

Deposition attorney 2: How come Dr. Complicated Evaluation found that?

Dr. Easy Evaluation 2: Well, Dr. Complicated Evaluation probably read the records instead of skimming them.

Steven C. Hickey, DC, DABCO, DACRB, IME, QME July 10, 2020

It is quite apparent that the QME system is dangerously understaffed, in all areas other than chiropractic. The exodus of QMEs from the system has been accelerating in recent years. There are several reason why, but at the forefront is the lack of increase in reimbursement. As a result, injured workers are often having difficulty obtaining QME evaluations in a timely manner. This has resulted in an undue burden on the DWC, Medical Unit, as evidenced by the ever increasing numbers of replacement panels on the basis of QME unavailability.

It is also apparent that QME demand is at a historic high and has been increasing at the same time that the QME population has been shrinking. The paradoxical situation, between QME physician supply and demand has never been greater, in the 26-years that I have served as a QME Evaluator.

Inadequate reimbursement is the main reason for QME physicians leaving the system. **QME fees have not been increased since 2006 despite DWC's statutory mandate under LC 5307.6(a) to do so regularly**. Untimely processing of payments, biased and bad faith fee reductions, including disregard for fair business practices, holding QMEs to a higher standard than, is another salient reason accounting for the decrease in QME providers.

QME report quality is consistently raised as a problem throughout the system. However, I personally find it prejudicial to require DCs to take additional training in report writing, etc.,…, when the vast number of Applicant Attorneys I speak to, would argue that DC reports are better written, provide more accurate impairment, and are more useful in settling claims. MDs, as a rule, have no better training in report writing, disability evaluation, or the proper application of the *Guides*, just because of their “degree.”

The proposed change to the fee schedule would reduce QME reimbursement on complex evaluations, further reduce report quality, and drive more providers out of the

QME system. This couldn't come at a worse time. With the system already understaffed, these changes would further jeopardize the stability of the QME program. So, if the DWC's intention is to "gut" the system by under-paying QME providers, then you are well on your way!

It seem all-too apparent, from this recent proposal and earlier actions that DWC is biased in favor of insurance carriers and places their financial interests ahead of the well-being of injured workers and the QME system they are charged with administering in good faith.

There is little irony that the proposed 2018 changes occurred in the immediate aftermath of Howard v. Baker. That lawsuit challenged DWC's enforcement of underground regulations to deny reappointment to countless QMEs. That case, after lengthy and costly adjudication, settled in mid-April 2018. In that settlement, DWC agreed to stop enforcing its "interpretation" of the medical legal fee schedule which Superior Court Trier of Fact felt were "probably underground regulations."

The current DWC administration marred its relationship with much of the QME community after denying reappointment to hundreds of QMEs on the basis of these underground regulations. Many QMEs felt that the settlement was a sign of hope and signaled that DWC was prepared to act in good faith with QMEs going forward. Instead, in 2018, the DWC elected to quickly attempt to change the fee schedule, and that proposal sought to reduce QME reimbursement, unjustly. The proposed changes seemingly codified many of the underground regulations which the DWC had just agreed to stop enforcing. The 2018 fee schedule reductions reportedly generated over 500 pages of comments from the QME community.

Following the backlash of the negative comments, DWC proffered a new proposal in August of 2019. This proposal was also noted to have precipitated several hundred pages of disheartened comments the QME community. Odd that the August 2019 proposal was issued during the time DWC was being formally investigated by the California State Auditor related to its mismanagement of the QME program. The State Auditor investigated DWC's reliance on underground regulations. She raised the issues as to whether DWC had properly managed the QME fee schedule, noting that the DWC had failed to update the medical-legal fee schedule since 2006.

At the time of DWC's 2019 proposal, the State Legislature had just introduced AB1832, a bill aimed at increasing QME reimbursement, owing to the fact that the DWC had failed to do so in the prior 13 years. The DWCs 2019 proposal would have resulted in substantially lower reimbursement for QMEs than the increase contemplated by AB1832.

Furthermore, the August 2019 proposal was concerning because it did not readily involve input from any stakeholders. In years past, stakeholders had been extensively involved in making important policy changes, such as a new fee schedule. But, rather than taking a more measured and collaborative approach, DWC, in August 2019, attempted to circumvent the State Legislature, the State Auditor and numerous stakeholders, in order to reduce QME reimbursement. It should come as no surprise, that numerous documents obtained from a Public Records Act, served on the DWC in 2019 revealed that DWC's August 2019 proposal was an amalgamation of various insurance industry proposals.

It is quite apparent, that the overwhelming consensus favorite of the QME community, was in support of the fee schedule proposal outlined by the Honorable Sue Honor. It is now clear that the DWC ignored the input of QME stakeholders, as your current proposal is wholly unacceptable, self-serving the interests of the insurers, and will undermine the QME industry, as countless practioners will "opt-out," should your current proposal go forward.

For the past fifteen years, without explanation, the DWC has failed to follow its statutory mandate under LC5307.6(a) to simply grant QMEs a reasonable fee increase.

DWC has adjusted the OMFS over 60 times since 2014. Yet it has failed to increase the medical-legal fee schedule during this time frame.

These actions, or lack thereof, have been compounded by DWC circumventing the legislature and, most recently, ignoring the recommendations of the California State Auditor.

California's medical providers and the injured workers they treat, including the QME medical-legal providers, deserve a fair, impartial, and nonprejudicial DWC, who's actions seem to side only with the interests of the insurers.

Having served this State, its inhabitants and my community for 36-years, 26 of such as a QME, I vehemently oppose DWC's proposed changes to the medical legal fee schedule. These proposed changes will serve only to create increased friction between the QME community and the DWC, adding unnecessary costs of litigation to today's miserably broken QME system.

In addition to reducing reimbursement(s), and underscoring the value of time required to address extraordinary and complex evaluations, a flat fee model will result in a decline in report quality, of that you can rest assured. In this context, DWC's proposal does not make sense, and since the QME pool is aging, your failure to recognize that attracting "new" QME s, will most definitely be complicated, if not otherwise impossible.

As countless QMEs have already pointed out, responding to the 2018 and 2019 proposals, moving forward with this current DWC proposal would have calamitous implications for an already understaffed QME system. **According to the Judges I have spoken to, including Trial Litigators on both sides of the isle, the QME system cannot afford to lose the masses of QMEs who will quit if this proposal moves forward**.

I implore the DWC, and the "other" stakeholders, to listen heed the warnings from the aging and diminishing pool of QMEs, which DWC, by its purposeful actions, has alienated and marginalized. A workable fee schedule can only result from a process that is transparent, fair, and one in which QMEs are treated with respect and professionalism, being reimbursed for their time and effort, which in my opinion is so badly misunderstood.

We respectfully request that DWC adopt a workable fee schedule. Please consider the proposal by Sue Honor. I t would be wholly unfair to adopt a new fee schedule that is less than that of the State of Nevada, where arguably the cost of living is far less than California.

Bruce J. Dreyfuss, M.D. July 10, 2020

To follow are comments on the proposed Medical-Legal fee schedule:

Following a recent audit, there was to be a 30% increase in the reimbursement to QME evaluations. The proposed fee schedule does not meet such an increase.

As an internist, I am invariably requested to evaluate injured workers for internal medicine conditions whose association with a work injury is contested. Evaluation of such conditions is almost without exception a complex undertaking. The new fee schedule has done away with the previous complexity factors so there is no way to account for the time and effort and research such an evaluation requires. Instead, and by default, functioning as a complexity proxy, a per page billing rate of $3 per page is allowed. That represent only a 20% increase. Further, only $2 per page is allowed for each page beyond 2000 pages. That represents 38% decrease. The more complex, the less is paid. That's certainly backward. Not acceptable.

The definition of a page is not fixed. That's surely an oversight? The definition must be stated unambiguously, 81/2 x 11 inches. 12 or greater font. Double spaced. Single sided.

Follow-up evaluations cover a period of 24 months. By experience, there are substantial changes in the injured worker's situation after only 9 months. It must be changed.

A new category "Remedial Supplemental Evaluation" is created. This is an ***a priori*** and unilateral declaration that an initial or prior report failed for any number of reasons and must be remediated without compensation. And who but the defense/payor will make that determination. Not acceptable.

Reports must have taken into account the available medical records, but such medical records can be received at anytime prior to report preparation, perhaps only one day before. If there is simply not enough time to review all the records before a report deadline, the report will be deficient, and subject to "Remedial Supplemental Evaluation" punishment. Unacceptable.

A page count is to be performed by the evaluating QME, and must be attested to under penalty of perjury. REALLY? If I'm off by one page in 1879 pages I'm in trouble. I'm pretty good at math (a minor in college) but this is taking it too far. Unacceptable.

Current regs call for the MLFS to be adjusted every time the OMFS is adjusted. But this hasn't happened in 15 years! Fix it!

It's about time the medical legal fee schedule reflects the work done by QMEs and is paid in2020 dollars and is COLA adjusted to keep paying in current dollars.

This has been going on for more than one year. Unacceptable.

Farzad Rabbany, DC, QME July 10, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,800 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

Sue Honor’s proposal and the accompanying petition can be found here:

https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

Ripu Arora, MD, MBA, QME July 10, 2020
Peninsula Interventional Pain Center

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This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Stephanie M Janiak, DC, DD, IIE, QME July 10, 2020

I have been a qualified medical evaluator in the state of California now for two years. One thing I am consistently told by everybody that there are not enough doctors in the system. I find it frustrating that the DWC would propose a fee schedule for PQME's that would lower the rate. The lack of financial reimbursement will drive good doctors from the system and not entice any new ones to join.

If the rate is lowered to the proposed fee schedule I myself may not be able to financially afford to see claimants. The requirements for reports far exceeds the proposed payment. It is not realistic for me to spend 10 to 20 hours writing a report that with research exceeds 40 pages for $1600. Especially when out of that payment I have to arrange travel, pay a facility, billing, records collection, and multiple administrative duties. The reduction would force me to operate in the negative and I would have to leave the program.

Laura Beltran, Psy.D., QME July 10, 2020

As a QME I find the proposed fee schedule to be inadequate and unreasonable given the degree of work required to complete these evaluations. These evaluations cannot be completed by an psychologist or psychiatrist. It takes special certification and going CEU's to maintain this knowledge and experience in this specialty. With the proposed changes it would not be cost effective for me to continue as a QME. The proposed schedule fee is equivalent to, if not less than conducting a regular psychological evaluation without the special certification and additional fees to maintain QME status. By process of attrition related to the proposed schedule fee, injured workers stand to be the most harmed with respect to psychological claims. It raises concerns of who stands to prosper from these proposed changes, which ultimately would be insurance

companies. The basis of creating this system was to assist and protect injuries workers and employers.

It is my opinion that psychological and psychiatric QME interviews and reports will not be adequately compensated by a 1.5 modifier. This will result in the attrition of psych QMEs, especially psychiatrists, as this pay will not compensate the number of hours required at a competitive rate. The modifier needs to be at least 2.5 to 3.0, and, at the lower rate, should include additional modifiers for Rolda and any past psych claims. The psych modifier should apply not only to the base rate but also to record review as the content of the records is frequently more dense including past psychiatric records, personnel records and other documentation. With the current regulation, psych QME's generally held to a higher standard of record review than other QME specialists. Records are personally reviewed by the QME, which warrants modifiers to be applied to record review and base rate.

The current proposed fee schedule is suggesting $2 a page for records over 1800 pages. At the commonly accepted rate of 100 pages per hour, this works out to be $200 an hour, which is LESS than the current fee schedule rate of $250. This would be a pay cut rather than he described pay increase that this fee schedule calls itself. All pages need to be paid at $3 per page. Records provided for psych evaluations are important to when trying to gather a comprehension history and better understand past psych history or the trajectory of their psych impairments.

It is important for doctors to receive records before the evaluation in order to perform a comprehensive history gathering. There should be a proposed cut off no longer than the day of the evaluation to ensure all relevant information is obtained. This process is extremely important with respect to making decisions such as apportionment, treatment, etc. that will ultimately impact the injured worker. Many injured workers have encountered several doctors in different disciplines through their process and it can be challenging trying to remember important details of those encounters, records provide an opportunity to better understand the complexities of each unique evaluation. If we are required to include records received at any time prior to issuing of the report, this is bound to cause delays in reporting and even late reports, which will just complicate the system, causing delays, denied reports, and requests for new panels.

A 24 month period is a considerably lengthy period of time in which too much time has lapsed and many interpersonal and environmental factors have changed. At this time, it would not be considered a re-evaluation, instead it would feel more like an initial evaluation. The amount of records and interim information can be extensive and the re-evaluation rate is inadequate for this. The span should be no more than 12 months.

It is necessary for the DWC to add an automatic annual fee increase so that QMEs are not without a raise for several years as has occurred since the last fee schedule

change. A fee schedule that does not include this will be incomplete. Again, being a QME requires special certification, training, and ongoing CEU's to maintain competence and speciality in this area. It seems fair to allow for a raise to compensate QME's for the speciality.

Gabor Vari, Chief Executive Officer
California Medical Evaluators
Board Member, California Society of Industrial Medicine

July 10, 2020

California Medical Evaluators ("CME") is a leading QME practice management company headquartered in Los Angeles. Our network of QME physicians performs thousands of QME, AME and IME evaluations annually. CME is a DWC-accredited QME continuing education provider and, as such, CME trains and mentors QMEs to improve the overall quality of QME reports. We welcome this opportunity to contribute to the dialogue on proposed changes to the medical-legal fee schedule regulations.

Before going into detail, we would like to make a few general comments:

1. The QME system is dangerously understaffed, especially in key specialties like orthopedics, and the exodus of QMEs from the system has been accelerating in recent years. As a result, injured workers are having difficulty obtaining QME evaluations in a timely manner as evidenced by the growing numbers of replacement panels on the basis of QME unavailability.
2. QME demand is at a historic high and has been growing at the same time that the QME population has been shrinking. The **mismatch between QME physician supply and demand has never been greater**.
3. Inadequate reimbursement is one of the main drivers of QME physicians leaving the system. **QME fees have not been increased since 2006 despite DWC's statutory mandate under LC 5307.6(a) to do so regularly.**
4. QME report quality is consistently raised as a problem throughout the system.
5. **The proposed change to the fee schedule would reduce QME reimbursement on complex evaluations, further reduce report quality, and drive more providers out of the QME system**. This couldn't come at a worse time. With the system already understaffed, these changes would further jeopardize the stability of the QME program.

Background

Before addressing the specific proposed changes, we would like to comment on the background, and specifically, timing of this proposal as well as prior fee schedule proposals from DWC. In short, it is clear from its actions that DWC is biased in favor of insurance carriers and places their financial interests ahead of the well-being of injured workers and the QME system they are charged with administering in good faith.

The proposed 2018 changes occurred in the immediate aftermath of *Howard v. Baker.* That lawsuit challenged DWC's enforcement of underground regulations to deny reappointment to countless QMEs and settled in mid-April 2018. In that settlement, DWC agreed to stop enforcing its "interpretation" of the medical legal fee schedule which Superior Court Judge Chalfant felt were "probably underground regulations." The current DWC administration soured its relationship with much of the QME community after denying reappointment to hundreds of QMEs on the basis of these underground regulations. Many within the community felt that the settlement was a sign of hope and signaled that DWC was prepared to act in good faith with QMEs going forward. Instead, DWC elected to scramble and quickly attempt to change the fee schedule in order to slash QME reimbursement. **The 2018 proposed changes sought to codify several of the underground regulations which DWC had just agreed to stop enforcing.** This proposal generated over 500 pages of outraged comments from the QME community.

Following the backlash of negative comments, DWC came out with a new proposal in August of 2019. This proposal was also followed by several hundred pages of angry comments from QMEs.

The August 2019 proposal was issued during the time DWC was being formally investigated by the California State Auditor related to its mismanagement of the QME program. The auditor investigated DWC's reliance on underground regulations and whether DWC has properly managed the QME fee schedule which DWC had failed to updated since 2006. (The Auditor's finding are described in detail further below.)

Additionally, at the time of DWC's 2019 proposal, the Legislature had just introduced AB1832, a bill aimed at increasing QME reimbursement because DWC had failed to do so in the past 13 years. The August 2019 proposal would have resulted in substantially lower reimbursement for QMEs than the increase contemplated by AB1832. Another reason the August 2019 proposal was concerning was because it did not involve input from any stakeholders. In the past, stakeholders had been extensively involved in making important policy changes, such as a new fee schedule. But, rather than taking a more measured and collaborative approach, **DWC, in August 2019, attempted to**

make another end run around the Legislature, the California State Auditor and several stakeholder groups in order to reduce QME reimbursement.

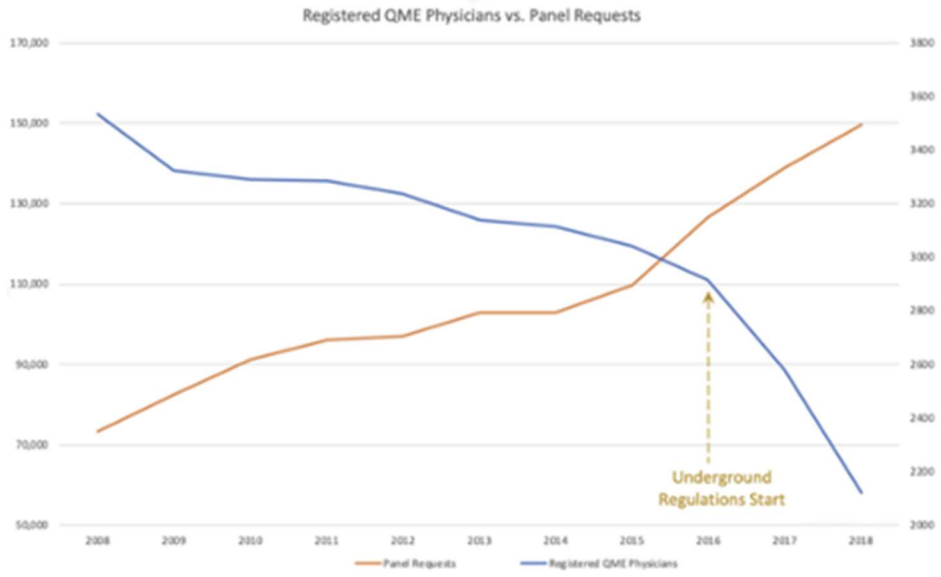
Documents obtained from a Public Records Act request submitted to DWC in 2019 revealed that **DWC's August 2019 proposal was an amalgamation of various insurance industry proposals.** In contrast, the consensus favorite proposal of the QME community, the Sue Honor fee schedule proposal, was ignored by DWC. This proposal has garnered over 2,800 signatures of support; however, DWC continues to ignore it in favor of proposals biased towards insurance carriers. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

The below table demonstrates that most financial terms from DWC's August 2019 proposal were directly copied from, or heavily influenced by, insurance carriers while Sue Honor's recommendations were disregarded.

Service	**August 2019 DWC Fee Schedule Proposal**	**Insurance Company Recommendation**	**Sue Honor Recommendation**
Initial Eval Flat Fee – non-psych	$1,650	$1,560 (CWCI proposal), $1,800 (SIA proposal as "average" cost of initial eval)	$2,200
Initial Eval Flat Fee – Psych	$2,475	$2,498 (CWCI proposal), $2,500 (SIA proposal)	$3,850
Re-Eval Flat Fee – non-psych	$1,100	$625 - $875 (SIA proposal)	$2,200
Re-Eval Flat Fee – Psych	$1,650	$1,500 (SIA proposal)	$3,850
Pages of Records Reviewed Included in Flat Fee	400	400 (CWCI proposal), 100 (SIA proposal)	50
$/page In Excess of	$2/page	$2/page (SIA proposal)	$5.50/page

Service	August 2019 DWC Fee Schedule Proposal	Insurance Company Recommendation	Sue Honor Recommendation
Included Pages			
Supplemental Report Flat Fee	$275	$225 (CWCI proposal), $360 (SIA proposal)	$1,000
Missed Appointment Fee	$0	$312 (CWCI proposal), $250 – 500 (SIA proposal)	$1,000
Hourly Deposition Rate	$424	$400/hour (SIA proposal)	$600

Below is a graph which summarizes the current **QME crisis,** specifically the widening gap between QME supply and demand.



DWC's Failure to Update Medical-Legal Fee Schedule Since 2006

The trend of declining QMEs has been accelerated by DWC's underground regulations, ongoing "enforcement" efforts against QMEs, and **failure to update the medical-legal fee schedule since 2006. As explained in detail below, DWC has a statutory requirement to update the QME fee schedule every time it updates the treatment fee schedule.**

Labor Code 5307.6(a) states, in relevant part, the following:

> (a) The administrative director shall adopt and revise a fee schedule for medical-legal expenses as defined by Section 4620 … at the same time he or she adopts and revises the medical fee schedule pursuant to Section 5307.1.

Section 5307.1 is related to the Official Medical Fee Schedule ("OMFS") which dictates reimbursement for physician services, pharmaceuticals, pathology and clinical laboratory services, hospital outpatient and ASC services, inpatient hospital services, DME, prosthetics, and ambulance fees.

Between 2014 and January 2020, the OMFS was updated over 60 times (https://www.dir.ca.gov/dwc/OMFS9904.htm) by the Administrative Director. During that same time period, the Administrative Director updated the medical-legal fee schedule zero times despite being required to do so the same 60+ times.

Had DWC updated the medical-legal fee schedule regularly, as required by law, then QMEs would be reimbursed much more reasonably today. In contrast to the medical-legal fee schedule, DWC annually updates the Statewide Average Weekly Wage in order to ensure that injured workers are receiving appropriate adjustments to their financial benefits. SAWW increased from $838.42 in 2006 to $1,325 in 2020. Therefore, **financial benefits for injured workers increased 58% during the same time period that QMEs saw no increase whatsoever.**

State Auditor Findings

In November 2019 the California State Auditor released report 2019-102 entitled, "Department of Industrial Relations: Its Failure to Adequately Administer the Qualified Medical Evaluator Process May Delay Injured Workers' Access to Benefits." The Audit exposed numerous systematic failures by DWC to properly administer the QME system including:

- … DWC has not taken sufficient action to address its QME shortage. For example, *it has not taken one key step that could help it attract and retain QMEs: updating the rates of its medical-legal fee schedule*—the fee schedule QMEs use to charge for their services. This fee schedule's rates have not been updated since 2006. *However, state law requires DWC to adopt and revise the medical-legal fee schedule in tandem with its Official Medical Fee Schedule (OMFS), which establishes reasonable maximum fees paid for specific workers' compensation medical services. Although DWC updated the OMFS multiple times from 2014 through 2018, it has not updated the rates in the medical-legal fee schedule for QMEs in 13 years.* … Consequently, QMEs are billing for their services at 2006 rates, which are much lower than what the rates would be if they had kept pace with inflation. (emphasis added)
- Although DWC is responsible for overseeing QMEs and administering the process for selecting QMEs to examine workers, it has not adequately ensured that it has enough QMEs to keep up with the demand for their services.
    - From fiscal years 2013–14 through 2017–18, the total number of QMEs decreased by 12 percent and requests for QMEs increased 37 percent.
- DWC inappropriately used its reappointment process to discipline some QMEs alleged to have committed overbilling violations, which raises due process concerns.
    - DWC lacks sufficiently detailed, written policies and procedures for investigating and resolving complaints.
- DWC has not continuously reviewed QME reports for quality and has not tracked when workers' compensation judges have rejected QME reports that failed to meet minimum standards.
    - Low-quality QME reports can delay injured workers' receipts of benefits and add expenses for employers involved in disputes.

The comprehensive and thorough audit report delves into many other systematic failures by DWC related to the QME system.

After reviewing the results of the audit, the Joint Legislative Audit Committee ("JLAC") called for a special oversight hearing in the State Capitol. This was important because such hearings are only held for audits with the most egregious findings. I was honored to testify at this hearing along with CSIMS President Jacob Rosenberg and Nicholas Roxborough. https://www.youtube.com/watch?v=A-YPhIpVuMU

DWC Administrative Director George Parisotto also testified at this hearing. Several legislators asked Mr. Parisotto about the staggering exodus of QMEs in recent years. He was also asked why DWC does not simply increase the QME fee schedule. Mr. Parisotto testified that DWC has been working hard since early 2019 to determine next steps on the fee schedule. He also remarked that he was reluctant to simply increase fees stating, "I don't want to throw money at the problem. We increased fees in 2006 and that didn't stop QMEs from leaving the system."

Continuing the trend identified by the auditor, the QME community finds itself, again, reviewing a flawed proposal from DWC that will harm QMEs but enhance insurance carrier profits. Unsurprisingly, the current proposal by DWC would result in lower compensation for many complex reports than the current 2006 fee schedule. The importance of producing high-quality medical-legal reports that constitute substantial medical evidence, especially in complex cases, cannot be understated. Any revisions to the MLFS should aim to enhance, not reduce, the quality of these reports.

Before getting into the details of the proposed fee schedule, we would be remiss if we did not point out that the fee schedule proposed by DWC ignores and undermines much of the work done in recent stakeholder meetings. In the Fall of 2019, DWC finally began hosting stakeholder meetings between QMEs, QME groups, and insurance carriers, after being asked to do so for years. Such meetings occurred through January of 2020. CME was present at each of these meetings. The outcome of these meetings was a consensus between the stakeholders on the nature and substance of a new fee schedule proposal. We are shocked and disappointed that the present proposal from DWC does not accurately reflect the consensus that was found at the stakeholder meetings. Instead, this proposal materially modifies that consensus in favor of insurance carriers. Each change which DWC made after the stakeholder meetings solely benefits insurance carriers. None of the changes benefit QMEs. Simply put, **DWC did not honor the integrity of the stakeholder process and gave the payors much more favorable terms than even the carriers agreed to.** Such a "switcheroo" demonstrates the **ongoing bias of DWC against QMEs and injured workers and toward insurance carriers' financial interests**. Based on the prior conduct of DWC and the scathing findings of the State Auditor's report, it is shocking that DWC yet again chose to violate the trust of the QME community solely for the financial benefit of insurance carriers.

Proposed Changes

DWC's proposed fee schedule borrows heavily from the structure of the Nevada IME fee schedule which can be found here (on page 6):
http://dir.nv.gov/uploadedFiles/dirnvgov/content/WCS/MedicalDocs/2020%20NMFS.pdf

Just like its August 2019 proposal, **DWC's proposal is best summed up as a Nevada fee schedule without Nevada dollars**. This is particularly concerning in light of the fact that Nevada is a much lower cost-of-living state (with no income tax) than California and that medical-legal evaluations in Nevada's WC system are much simpler than those in California. See comparison below:

	Nevada Fee Schedule	**California DWC Proposal**
Minimum Flat Fee	$1,784.12	$2,015
Pages Included in Flat Fee	50	200
Reimbursement per page	$4.46 (pages 51+)	$3.00 (pages 201 – 2000) $2.00 (pages 2001+)
Organization of medical records in chronological order per page	$0.97	$0
Failed appointment fee	$669.04	$504
Evaluation of each body part in excess of the first 2	$334.52/body part	$0
Medical records required to be sent in an organized manner to doctor?	Yes	No
Cover letter required to specify number of pages sent to doctor?	Yes	No
Automatic Annual COLA Increase?	Yes	No

Additionally, DWC ignored many of the important elements of Sue Honor's proposed fee schedule, the consensus fee schedule which is supported by over 2,800 members of the QME community. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

See comparison below:

	Sue Honor's Proposal	**California DWC Proposal**
Minimum Flat Fee – non-psych	$2,200	$2,000
Minimum Flat Fee – psych	$3,850	$3,000
Pages Included in Flat Fee	50	200
Reimbursement per page	$5.50 (starting on page 51)	$3 (pages 201-2000) **$2 (pages 2001+)**

	Sue Honor's Proposal	**California DWC Proposal**
Supplemental report minimum fee – non-psych	$1,000	$650
Supplemental report minimum fee – psych	$1,750	$975
Organization of medical records if not received in an organized manner	$0.95/page	$0
Missed appointment fee	$1,000	$503
Reimbursement for time spent reviewing records for a missed appointment	$5.50 per page (starting on page 51)	**$3 (pages 201-2000)** **$2 (pages 2001+)**
Impairment rating (after first body part)	$500/body part	$0
Complex Apportionment Analysis	$400	$0
Face to face time in excess of first two hours	$400/hour	$0
Fee for cover letter/medical records sent late to QME	$500	$0
Medical records required to be sent in an organized manner to doctor?	Yes	No
Cover letter required to specify number of pages sent to doctor?	Yes	No
Premium for reports served on an expedited basis	5%	0%
Minimum COLA increase to fee schedule annually	4%	COLA Ignored
Allowance for electronic service of medical-legal reports and ANFs by QMEs	Yes	No
Requirement that parties notify QME of appointment cancellation	Yes	No
Requirement that parties copy QME on objections to QME's reporting	Yes	No

The response to this public forum has been loud and clear. QMEs do not like this proposal. Many will quit if this proposal moves forward. Based on the public forum

comments to date and the ongoing decline and aging of the QME population, DWC's proposal has further alienated and disengaged the skeleton crew of remaining QMEs.

As one of the foremost QME management groups in California, CME is supportive of Sue Honor's proposal. It should be noted that Sue Honor's proposal was written in 2018 and therefore additional increases in cost of living should be incorporated. Specifically, we endorse the following:

	California DWC Proposal	**CME Recommendation**	**CME Comments**
Comprehensive Medical-Legal Evaluation			
Minimum Flat Fee	$2,015	**$2,015**	
Follow-up Medical-Legal Evaluation			
Minimum Flat Fee	$1,316	**$2,015**	There is no clear evidence that work for a re-evaluation is consistently less than work for an initial evaluation. Therefore, both should be reimbursed equally.
Other			
Pages Included in Flat Fee	200	**50**	**Nevada is at 50 and California should be as well.**
Reimbursement per page	$3 (pages 201 – 2000) $2 (page 2001+)	**$5.50**	California should reimburse higher than Nevada's rate of $4.46.
Supplemental report minimum fee	$650	**$1,000**	DWC's proposal is grossly inadequate.
"Remedial Supplemental Report" Fee	$0	**Strike this section**	DWC should expect that this concept will increase friction, clog up the WCAB with litigation, increase QME dropout, and additional legal

	California DWC Proposal	CME Recommendation	CME Comments
			challenges against the Division.
Organization of medical records if not received in an organized manner	$0	**$0.97 per page**	This oversight by DWC is inappropriate. It should not be the QME's job to organize the medical records. Further, carriers should be incentivized to provide the records in an organized manner. We recommend at least the $0.97/page premium found in the Nevada fee schedule.
Missed appointment fee(2)	$503	**$1,000**	Missed appointments must be guaranteed reasonable reimbursement.
Specialty-based multiplier	1.50 for psych with increases for AME status and/or interpreter needed	**1.50 for neurology, pain medicine and internal medicine** **3.0 for psychiatry and psychology**	The multiplier should be tiered to recognize incremental complexity between the various medical specialties.
Specialty-based multiplier applies to:	Flat Fee Only	**Flat Fee and Per Page Fee**	The multiplier must be applicable to both the flat fee and per page fee. Record review is incrementally more complex for various specialties and this should be recognized by the application of

	California DWC Proposal	CME Recommendation	CME Comments
			the multiplier against the per page fee.
Impairment rating (after first body part)	$0	**$550/body part in excess of the first body part.**	The flat fee is meant to account for only the simplest evaluations. Therefore, there should be a premium payable for each body part rating in excess of the first body part.
Complex Apportionment Analysis	$0	**$500**	The flat fee is meant to account for only the simplest evaluations. Therefore, there should be a premium payable for complex apportionment analyses.
Face to face time in excess of first two hours	$0	**$425/hour**	The flat fee is meant to account for only the simplest evaluations. Therefore, there should be an hourly rate payable for extended face to face time.
Medical Research reimbursement	$0	**$425/hour**	The flat fee is meant to account for only the simplest evaluations. Therefore, there should be an hourly rate payable for medical research.
Fee for cover letter/medical	$0	**$500**	The parties should be incentivized to

	California DWC Proposal	CME Recommendation	CME Comments
records sent late to QME			provide the QME with a cover letter and medical records on a timely basis. The QME should be paid a premium for reviewing cover letter/documents which are received untimely. They should arrive at least 15 days prior to the evaluation.
Medical records required to be sent in an organized manner to doctor?	No	**Yes**	The administrative burden of sorting, organizing, de-duping the medical records should not be placed on the provider. If the parties do provide the records in a disorganized manner then the QME should be compensated additionally for the administrative work the parties elected not to perform.
Cover letter required to specify number of pages sent to doctor?	No	**Yes**	The parties should have the burden of specifying the number of pages provided to the evaluator, not vice versa.
“Page” defined to prevent gamesmanship (e.g. double-sided print-	Inadequate	**Yes**	Definition of page must be standardized. (1)

	California DWC Proposal	CME Recommendation	CME Comments
outs, condensed pages, etc.)			
Premium for reports served on an expedited basis	0%	**5% if served 10 or fewer days after evaluation**	QMEs should be rewarded for helping the parties move the case forward.
Minimum COLA increase to fee schedule annually	COLA Ignored	**Greater of 4% or annual increase in CPI for Medical Care**	DWC has included COLA increases in other fee schedules such as the copy service fee schedule. The lack of a COLA increase over the past 15 years for the MLFS is a huge current issue. **This is an egregious omission.**
Allowance for electronic service of medical-legal reports and ANFs by QMEs	No	**Yes**	Because of financial and environmental reasons, QMEs should be allowed to be serve reports electronically. Accordingly, QME Form 122 and the ANF declaration of service should be updated to allow an option for electronic service.
Requirement that parties notify QME of appointment cancellation	No	**Yes**	Currently, QMEs are often left in the dark about an appointment being cancelled by the parties until the day of or before an appointment. The parties should be

	California DWC Proposal	CME Recommendation	CME Comments
			required to timely give notice to the doctor about a cancellation.
Requirement that parties copy QME on objections to QME's reporting	No	**Yes**	Currently, QMEs are not required to be notified of objections to their reporting which can impact the collectability of their bill. DWC should require that QMEs be notified by the objecting party for any and all objections to their reports and/or bills.
Underserved Specialty Premium	0	**1.50 multiplier with escalations for more underserved specialties**	As a matter of policy, DWC should incentivize providers of underrepresented specialties to join the QME program.

(1) The term "page" must be defined and standardized. We suggest
- 12-point or larger Times New Roman, Calibri, or Arial font (cover letters)
- Original font size (medical records)
- Actual number of deposition pages (i.e. in a condensed deposition that has 4-pages shrunk to fit on each page, each actual page of the deposition is counted – i.e. a 40-page deposition transcript equates to a 10-page condensed deposition transcript à 40 pages would be included in the record count) or require non-condensed deposition transcripts
- Single-sided and 8 ½ x 11" ONLY (larger dimensions should be prohibited)

- Duplicates/redundant medical records/UR/IMR/prescriptions, etc. are counted with equal weight including prior reports from the same medical legal evaluator that are sent with requests for re-evaluation or supplemental report(s)
- Parties sending medical records must each declare under penalty of perjury the total page count they sent with proof of service
- Evaluators must declare under penalty of perjury the grand total page count in the report (of all medical records received/reviewed)

- Review of summary reports will be counted
- If medical records are sent on CD, then all non-subpoenaed records must be combined in one PDF file (not separate), and each subpoenaed medical record must be in separate PDF files. The subtotal page count for any CD will be based on the number of pages in the PDF files (i.e. if subpoenaed records say 100 pages, but the PDF file is 105 pages, then 105 pages will be counted)
- The evaluator must add all of the records sent from the various parties to achieve a grand total
- If there are disputes related to any portion comprising the total records reviewed, then there needs to be a streamlined adjudication process developed and administered by DWC to address these disputes

(2) Definition of a missed appointment should be expanded to allow for:

- injured worker leaves prior to completing the evaluation
- interpreter does not show up for the evaluation
- interpreter leaves prior to completing the evaluation
- evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h)
- evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)

Conclusion

For the past *fifteen years*, DWC has failed to follow its statutory mandate under LC5307.6(a) to simply grant QMEs a reasonable increase at the same time that it adjusts the OMFS. While DWC has adjusted the OMFS over 60 times since 2014, it has increased the medical-legal fee schedule zero times during this time frame. This has been further compounded in recent years by DWC circumventing the legislature and, most recently, ignoring the recommendations of the State Auditor. California's medical providers and injured workers deserve better than this.

We oppose DWC's proposed changes to the medical legal fee schedule. These changes will add more friction and litigation to today's broken QME system in addition to reducing reimbursement for complex evaluations. As many others have pointed out in these comments, **a flat fee model will result in a decline in report quality. DWC has already identified that QME report quality is a problem system-wide. In this context, DWC's proposal does not make sense**. As countless QMEs have already pointed out in this forum, moving forward with this proposal would have disastrous

implications for an already understaffed and unstable QME system. The QME system cannot afford to lose the masses of QMEs who will quit if this proposal moves forward.

As a leading management company and advocate for QMEs, California Medical Evaluators once again implores DWC to listen closely to the diminishing pool of QMEs which it has alienated and ostracized through recent acts of neglect and persecution. We believe that a workable fee schedule can only result from a process that is transparent with clear, known steps and in which QMEs are treated with respect and professionalism.

We respectfully request that DWC adopt a workable fee schedule such as that proposed by Sue Honor or adopted by Nevada.

Kenneth H. Geiger, M.D., Nuerologist July 10, 2020

The proposed recommended fee schedule changes are quite complex and may have many unintended consequences. The current system is functioning, but many QMEs have dropped out, probably in part due to the complexities of the QME evaluations and the inadequate reimbursement. The easiest solution would be to keep the current system, but increase the reimbursement rate and add an annual COLA increase. Since 2004 when the last fee increase occurred, Social security benefits have increased by 35%.

In my experience, every ML104 QME report is at least as complex as the ML104-94 AME report. All ML 104 reports should be reimbursed at the AME rate as they are of equal complexity.

The recommended changes in the fee schedule probably represent a fee increase for the basic QME ML102 & 103 Evals, but almost all of the QME Evals that I perform are ML104> Then proposed changes in the fee schedule would probably be a fee decrease. I doubt that I would continue to perform ML 104 Evals with this fee decrease.

It doesn't make sense to pay a physician per page reviewed. Otherwise I would envision that you may just get a list of Doctor names and dates. Reducing the fee per page after 2000 pages seems like a volume discount, but more pages typically means more complex issues, multiple industrial injuries, multiple non-industrial conditions or a combination of these issues. If anything, the fee per page should increase as the number of pages increases. I would additionally point out that with the age of computerization, medical records have become much more complex to review. For example a Kaiser physician refers a patient for an MRI scan. The test is performed.

Thereafter with multiple visits thereafter, the MRI report will be added to the re-evaluation appointment visit. Considerable time has to be spent to put the medical records in chronological order prior to my review. The carrier should provide the records in chronological order and remove all duplicates. Physicians should be required to review the records in chronological order. Some review the records in reverse chronological order or in chronological order for each source of records such as physician, clinic or hospital. QMEs should be provided with all of the medical records, not summaries by other physicians in their reports. An orthopedic surgeon may not summarize neurological symptoms in reports they are reviewing, only the orthopedic.

A standard page in medical records in 8.5 x 11 inches. Suddenly the DWC or carriers want to pay the physician per 8.5 x 14 inches, the so-called legal page, a further reduction in payments to the QME.

Any bill for a re-evaluation should not change from the current 9 months. Thereafter, so much has changed that it is similar to see the patient for the first time.

The definition of a missed appointment should be cancellation of the appointment by either party within 7 calendar days prior to the appointment or if the patient or interpreter does not appear for the appointment.

A neurological evaluation is more complex than most evaluations. If there is to be any increase a fees for particular specialties, the fee increase should also cover neurological evaluations.

There should be a requirement that the medical records should be provided to the QME or AME 2 weeks prior to the evaluation or the evaluator can postpone the appointment.

If there are more than 500 pages of medical records the QME/AME should be given 60 pays to complete the report.

I am also troubled by the fact that the stakeholders involved in the proposed fee schedule met and there were some agreements. Those agreements have now been changed with reduced fees to the physicians.

If medical records are sent to the physician by pdf or CD-ROM, there are postage and printing savings for the carrier or attorney. The medical offices should be reimburse per page for printing the medical records. The medical office are using paper, toner cartridges, printer wear and tear, and employee time to print the medical records. My office has printed a 60-inch stack of medical records for one patient!

Condensed copies of depositions should not be provided to physicians. They are difficult to read after multiple photocopies have been made. Does 1 page with 4 pages

of a deposition transcript count as 1 page or 4 pages. Who is going to count the pages? Is that another point to litigate? Cover letters should count as pages reviewed.

There's an expression "If you pay peanuts, you get monkeys." Currently, ML fees are peanuts compared to current legal fees. Related to a divorce, I'm paying $775 per hour in attorney fees. The recommended fee change represents a fee decrease for most QME evaluations. Reviewing a 100-page deposition for $300 or $200 doesn't even cover my office overhead let alone provide income. As stated earlier, the current system is working, but there needs to be a significant COLA increase to keep quality QMEs in the system and get more to apply. It my impression that over the years the requests for QME panels has increased but the number of QMEs has decreased. This fee change will not solve that problem.

Please do not try to solve the current QME problem with an ill-conceived fee schedule that will certainly disrupt the entire process.

Sung Cho, D.D.S. July 10, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,800 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

Sue Honor’s proposal and the accompanying petition can be found here: https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

The fact that you have disregarded essentially all of Sue Honor’s qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor’s recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

David Gorrie, D.C. July 10, 2020

I have been a QME since about 1991. The fee schedule you have proposed is ridiculously low when you consider how much time and work (preparation, record review, face-to-face, research, contemplation/consideration of facts, writing the report and etc. goes into a high quality QME report from any specialty. The current fee schedule is already low, please explain why you think your arbitrary fee schedule is fair, I'd really like to know! Good luck keeping the current QME doctors if your proposal is implemented.

Martha Singer MD July 10, 2020
Orthopaedic Surgery

Thank you for working to improve pay for QMEs. This is a huge step forward. I do want to suggest some additional considerations.

1. Eliminate AME status.
2. Increase all QME reimbursement by the 1.35 multiplier and consider more specialty differentials
3. Provide feedback, and enforce laws that ensure QMEs produce high-quality reports.
4. Revisit rules about practice requirements for QMEs since active practice not required for AMEs, and a good evaluator in a valued specialty benefits the goals of the system.
5. Evidence based guidelines for causation and apportionment
6. Reconsider pay differentials

How does the AME system serve the injured worker or the WC system? How is a separate “old boys’ club” system for evaluations justified? The AME is a special system available only if an injured worker has an attorney. An AME does not have to be a QME, and “need not have any special qualifications beyond being a licensed physician acceptable to both parties to a dispute…The DWC does not regulate AME’s.” (p61 Physician’s guide).

AME “status” confers higher pay, confers an alternate pathway to remaining a QME that is different than for other QMEs, and is so opaque that even the state auditor did not take a stab at reviewing it, other than to point out that un-represented injured workers have a different process from represented workers allowing them access to more QMEs (p2 auditor’s report), and that the DWC does not oversee AME’s in the same way it oversees QMEs. (p5 auditors report). This California State Auditors report of Nov 2019 was very critical of the availability, oversight and reimbursement of QMEs.

If there is some plausible argument that AME evaluators provide a better quality report, bring it on, because usually those arguments boil down to 4 things: chest thumping about how complex the issues they address are; 2. a criticism of QME reports from low quality evaluators, 3. some explanation of how an AME will provide something to please both the applicant and defense attorneys in the way of compromise, 4. some special understanding of Almaraz-Guzman, Benson, Kite, or other Named cases.

All QME reports should be of quality to be substantial medical evidence. The purpose of the move to the Guides to the Evaluation of Permanent Impairment, 5th edition, AMA, was to have uniform consistency in rating. All evaluators are asked to provide medical opinions that are fair, impartial, and based on their best medical judgment (p102, Physician’s guide). The report should represent a medical truth, and if there is some finagling and compromise involved in adjudicating the legal side of the case, that is not an appropriate issue for the physicians. We can answer medical questions the best, and some epidemiological questions. My AME report issues are not different than my QME issues, my orthopaedic QME reports can involve multiple body parts, multiple injuries, multiple employers, boxes of records and depositions. I have done QME reports over more than a decade on the SAME individuals, not because they were not permanent and stationary but because the case never closed.

Every QME educational conference I attend has smart attorneys talking about legal cases with names that they think doctors should be knowledgeable about, but part of the huge weakness of the evaluations is the shaky basis on which most causation and apportionment comments in reports are based. The medical basis for the legal arguments is sometimes weak, even in named cases. This is a significant area for improvement, the DWC could be setting some standards by using evidence based guides and epidemiologists to guide a more consistent system. Instead of trying to teach law to doctors and medical school to lawyers, there could be more dialogue about

what the medical and epidemiological evidence is and how it can guide topics like return to work. We can all Almaraz-Guzman.

I see that there are some awful report writers, and these individuals either need remediation or removal from the workers comp system. This has been a longstanding issue, and was addressed in the auditor's report which found the DWC to have failed to review QME reports for quality as stated in the law (p22, auditors report), and that low quality QME reports delay benefits to workers and add expenses for employers (p24). Remediation and removal of poor performers in the QME evaluator system can save time for the injured worker, with early assessment and resolution. I see poor reports that are costly to all parties, when an unknowledgeable evaluator may add in unrelated body parts, requests unnecessary testing or more of the same therapy, impose unnecessary work restrictions, and delay resolution of a case. Perhaps a supervised period of review for new evaluators would be in order.

When the DWC recognizes that the pay differential for AME evaluators is sustaining a separate club of evaluators, it may want to keep those evaluators as QMEs, as some are retired from active patient care practice but still expert evaluators. Allowing physicians no longer in active clinical practice in needed specialties to be QMEs is reasonable. But you also need to look at the pay differentials you have chosen, as you will never attract neurosurgeons by paying them like acupuncturists. You need to value the experts appropriately. I know you may not be able to do this at this moment, but this is obviously necessary. Thanks

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Annette Marie July 10, 2020

I have worked for doctors who do medical-legal evaluations in Workers' Comp for several years, and have more recently been working with a highly experienced and well-regarded Qualified Medical Examiner and Agreed Medical Examiner in Psychiatry practicing in Southern California.

As proposed, this prohibitive fee schedule would mean that the psychiatrist I work for would be unable to produce the kind of reports needed by Workers' Compensation. Without being fairly compensated for the doctor's time on an hourly basis, like other psychiatrists and psychologists, like the lawyers with whom the doctor works, and like other professionals, the doctor would no longer be able to work as either an AME or as a PQME, and I would be out of a job.

The doctor pointed out Labor Code 5307.6 to me. It's stated that doctors should receive "…fees which provide remuneration to physicians performing medical-legal evaluations at a level equivalent to that provided to physicians for reasonably comparable work, and

which additionally recognizes the relative complexity of various types of evaluations, the amount of time spent by the physician in direct contact with the patient, and the need to prepare a written report."

This flat fee schedule is impractical, confusing, open to misrepresentation and misinterpretation. Ultimately, it is unworkable. I would understand that, for psychiatrists, instead of a raise, this would be a major decrease in payment, where the doctor fears having to close the office.

I appreciate the opportunity to comment upon these changes and express my concerns for the far-reaching consequences of this proposal.

Sue Moss July 10, 2020

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I appreciate the opportunity to comment upon these changes and express my concerns for the far-reaching consequences of this proposal.

Sawn Benton, MBA July 10, 2020
Executive Vice President &CEO
California Chiropractic Association

Thanking Dr. Sarbjit Dhesi for submitting comments to the Medical Legal Fee Schedule Forum.

Michael Carlish, Ph.D., QME July 10, 2020

My name is Michael Carlish and I am a clinical psychologist and qualified medical evaluator. Previously I submitted a letter to the DWC about the proposed rule changes to our fee schedule, but I've since learned more about the issue I'd like to send this additional letter:

I am very concerned about the proposed changes. I believe that my compensation would be drastically reduced if the proposed changes went through, which is not fair considering how much time and effort goes into each report.

I believe that mental health evaluations are more complex and time-consuming than other evaluations, as reflected in the current billing code, and should be compensated accordingly. Psych evaluations take longer to complete, which in turn requires more time to formulate conclusions.

The proposed changes would negatively affect psychiatrist and psychologist QME's more than other specialty. If we are no longer compensated fairly for performing the long and complex evaluations that are required in our specialty, many experienced and competent QME's will either submit reports that are of lesser quality and usefulness, or simply walk away from the DWC. Both outcomes would hurt injured workers.

The number of available QMEs has been decreasing for many years, while the number of panel requests continues to increase. The proposed fee changes would make this problem worse, because it would reduce the pool of available mental health evaluators. I myself would have to seriously consider whether I want to continue acting as a QME, which is a shame considering how hard I've worked to gain proficiency over the past 5 years, and how much I value this role.

In my opinion, medical-legal fees represent a very small portion of the state budget, in which mental health evaluations make up only 10% of QME panel requests. I do not see how adequately compensating psych QME's would constitute a significant financial burden to the state.

The last change to the medical legal fee schedule was in 2006, which means that QME's have not received a cost-of-living adjustment in 15 years.

The current proposal does not represent the agreements reached at the stakeholder meetings. These agreements should be honored.

Specifically, I request that:

1) A minimum of a 3x modifier must be applied to all psychiatric and psychological reporting including initials, re-evaluations, supplementals, and record review.

2) The fee for reviewing a page of medical records should be $3 regardless of how many pages are submitted and regardless of the type of report requested. It makes no sense to compensate some pages $3 and other pages $2.

3) A page of records must be defined as double-spaced, single-sided, 12-point or greater font. No legal-size paper should be used.

4) Whomever submits medical records must list the records provided. Page counts must include cover letters and any documents provided. Records should be submitted electronically whenever possible and every page in the file counted.

Ideally, records should be DATE STAMPED.

5) The fee schedule should include an automatic annual cost-of-living adjustment.

6) Records received less than 15 business days prior to the date of the evaluation may be submitted as a supplemental report.

7) A re-evaluation should be defined as an exam requested within 11 months of a prior exam where the applicant is available for evaluation within 60 days after the request. If these conditions are not met, the evaluation and report should be billed at the initial rate.

8) The proposed unreimbursed "remedial supplemental evaluation" would be completely unfair. I agree with the CSIMS proposal to rectify this unacceptable clause.

9) The definition of a missed appointment needs to be improved.

Thank you for taking my concerns into consideration. I hope a fair solution can be reached.

Tammy Molidor, Vice President, Operations July 10, 2020

Southern California Orthopedic Institute

The QME Physicians of Southern California Orthopedic Institute ask that you please consider the following revisions to the proposed Medical-Legal Fee Schedule:

- Review of records in excess of 200 pages (or 50 if supplemental evaluation) should be reimbursed at the rate of $3.00 per page regardless of the total number of pages. Also, the page count provision shifts the burden on the QME to keep track of the number of pages. Records submitted to the QME for review should include the total page count. Lastly, other than verifying the number of pages reviewed within the QME's report, the MLFS does not appear to provide a mechanism for coding and reimbursement of those pages in excess of 200/50. A code should be established for the billing of additional pages.
- The 24-month timeframe for follow-up medical legal evaluations is too long; especially, if there has been a significant event or change in the injured workers status that would increase the complexity of the evaluation. In absence of additional regulations that address this, the timeframe should remain 9 months.
- The multiplier for AME should apply to all services performed by the AME.

Thank you to the DWC for working towards an improved Medical-Legal Fee Schedule.

Jay Slosar, Ph.D QME July 10, 2020

I'm a QME and Psychologist in practice for 35 years. I will not comment on all the many fine and detailed responses to the particulars of the rate proposals. However, as someone who was written about mental health care delivery and its history, I would like to respond from a broader perspective.

The flat rate proposal reminds me so much of managed care and capitation. This is great for those paying the bills and the insurers but these practices ultimately fail when patients can't get an appointment and quality goes down and providers offer the bare minimum or drop out. "Providers" is that denigrating term that has always been used as a synonym for highly trained professionals.

The battle continues today in the private insurance sector as more and more intense level of mental health services that are needed today are often restricted under that term of medical necessity or third parties limiting needed services for their own bottom line. But mental health professionals did win in March 2019 in a nationwide class-action suit decision (*Wit et al. v United Behavioral Health and Alexander Dalton v United Behavioral Health*) in which the payers denied more intensive mental health services.

In the end after being a psychologist for more than 30 years it comes down to the same old story. More and more is asked of psychologists and responding to the tremendous demands that exist for mental health services today. Pick an area and the demands are overwhelming. As more and more is demanded—including training and qualifications-rates of reimbursement always seem to go down and the professionals have to resort to even legal means just to simply protect their interests. Otherwise, rates just stay the same and in 2020 you are now paid a rate based on economic conditions of 20 years ago. Then a proposal is put forth to slash rates even more.

I don't think this will ever stop and the current proposals as I read them fit into the category and trends that I described above. QME evals are quite complex and involve many factors from a skilled clinician to document and address the issues of causation, apportionment, personnel actions and Rolda analysis and periods of disability and work restrictions for a psychological claim. That's a lot. So I look at the proposed changes and current discussion as the same old story for mental health professionals.

It will be interesting to see what happens, but if it's a further insult—I am out.

Dr. Cynthia Neal July 10, 2020

I am a clinical psychologist QME and have been since 2016. I am also a MDO evaluator for Department of State Hospitals in the California Department of Corrections and Rehabilitation.

I find the QME evaluations are complex and nuanced, requiring hours of thought and preparation in order to submit a product which will withstand the rigors of forensic scrutiny.

I will not be able to produce a quality product if the fees are reduced. I find the current fees barely adequate to cover the time and resources required to produce a quality product.

Therefore, if the current fee structure is reduced, I will be compelled to forfeit my QME standing, as I will not have my professional reputation compromised by the production of an inferior product.

Lawyers talk to each other and compare Doctors. I could not allow the production of an inferior QME product to compromise or besmirch my reputation in the legal community, and therefore compromise my MDO work.

I worked very hard to obtain my QME standing. I was told pass rates were in significant decline when I took my exam. I would hate to be forced to resign so soon after obtaining this credential.

Further, the lack of increase in fees for, as I understand, approximately two decades, has already compelled many QMEs to resign, as the work is often too labor intensive to be sustainable within the current fee structure. I most certainly do not want to be a causality of the current proposed decrease in fees.

Alison Magoun Moreno, Ph.D. QME July 10, 2020
Clinical Psychologist

I am writing a second time as I want to include a cc that I neglected to add the first time, and want to include some additional thoughts. I am a clinical psychologist who has been a QME for the past few years. I am very concerned about the proposed changes to the fee schedule. If enacted, this fee schedule will increase the administrative burden on QMEs, not compensate them fairly, and likely reduce the already record-low number of QMEs still left in the system.

I am especially concerned with learning that DWC has intentionally NOT applied the psych multiplier to record review. Reviewing medical records from a mental health perspective is inherently more time-consuming and complex than reviewing medical records for a non-psych specialist. There are many factors to consider including matters of consistency or lack thereof, malingering, previous psychological or psychiatric treatment, nonindustrial psychological factors, opinions of treating psychologists and psychiatrists, and records pertaining to non psychological conditions. I have found that valuable information is obtained from a careful and thorough review of such records. As a psychological QME who is very conscientious in forming my opinions, I believe that a careful study of and consideration of the records is essential. I urge DWC to increase the multiplier to at least 2.0x **and** apply the psych multiplier to record review fees, not just the flat fee.

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders. Why has DWC ignored this widely supported proposal?

Sue Honor's proposal and the accompanying petition can be found here: https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

Further, the fact that DWC has disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement DWC proposes is far below Sue Honor's recommendation and even less than the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as QMEs. Some left by their own choice while others were thrown out by DWC based on underground regulations. Many qualified physicians have avoided becoming a QMEs because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge DWC to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported

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Andrea Guzman, Claims Regulatory Director July 10, 2020
State Compensation Insurance Fund

State Compensation Insurance Fund appreciates the opportunity to provide input regarding the Division of Workers' Compensation's (DWC) proposed amendments to the Medical-Legal Fee Schedule. State Fund respectfully submits the following comments for your consideration.

Recommended revisions to the DWC's proposed regulations are indicated by underscore for added language and ~~strikeout~~ for deleted language.

I. **§ 9793. Definitions**.

Discussion:

Paragraph (e)(5) defines one type of "disputed medical fact" serving as the basis of the objection to a treating physician's medical determination: *"the employee's medical eligibility for rehabilitation services."* The term *"rehabilitation services"* is broad and does

not accurately describe the type of worker's compensation benefit that needs to be examined to determine the employee's medical eligibility for.

Recommendation:

State Fund suggests an accurate description of the workers' compensation benefit be given here, and recommends the following revision:

(5) the employee's medical eligibility for ~~rehabilitation services~~ supplemental job displacement benefits.

Discussion:

Paragraph (j) defines the term *"Medical research"* as part of these regulations, but this term is not used in the body of the proposed regulations, and can be better defined.

Recommendation:

State Fund recommends removing the definition if it will not be used or revising the definition as follows:

(j) "Medical research" is the investigation of complex medical issues beyond the general standard of knowledge in the prevailing medical community.

Discussion:

The DWC proposes a new term in its list of definitions under paragraph (n) with *"Record Review",* which includes defining what a page is. It should be noted that physicians can review records from the various parties: the claims administrator, the claimant, and the claimant's attorney. Claims administrators are liable for payment to the physician yet cannot control what "pages" are sent by the claimant's attorney to the physician to review, including duplicate records. As such, a more detailed definition of *"Record Review"* may provide clarity for reimbursement.

Recommendation:

For the reasons stated above, State Fund recommends the following revision:

(n) "Record Review" means the review by a physician of unique, previously un-reviewed documents sent to the physician in connection with a medical-legal evaluation or request for report. The documents may consist of medical records, legal transcripts, medical test results, and or other relevant documents.

II. § 9794. Reimbursement of Medical-Legal Expenses.

Discussion:

Paragraph (1) outlines the billing and reimbursement guidelines for X-rays, laboratory services and other diagnostic tests. Here, it is unclear in this section what *"other diagnostic tests*" refers to and whether charges may be billed outside of the Official Medical Fee Schedule(OMFS). Clarity is needed.

Recommendation:

State Fund requests clarification on what *"other diagnostic tests"* refers to. In addition, State Fund recommends revision of the following sentence to clearly state the purpose is for all charges to be covered by the OMFS and prohibit charges outside of the OMFS:

No other charges shall be billed ~~under~~ except as provided for in the Official Medical Fee Schedule in connection with a medical-legal evaluation or report

III. §9795. Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony.

The following comments concern paragraph (c) of this section and the proposed medical-legal(ML) codes and corresponding procedure descriptions.

Discussion:

ML 200: Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation

Here, the proposed text of this regulation presents a potential issue with interpretation on the reimbursement rate for a physician's review of records based upon the number of pages reviewed.

The proposed language under Procedure Description outlines a tiered structure as to how and what rate a physician will be reimbursed for reviewing records. Here, the proposed text may be read and interpreted different from the DWC's intent with establishing a reimbursement rate of either $3.00 or $2.00 per page based upon the number of pages reviewed. Using language of "… *in excess of 200 pages, up to a limit*

of 1800 additional pages" in defining the reimbursement rate of $3.00 per page creates this uncertainty that may be interpreted as creating a gap in the number of pages that will be reimbursed at $3.00 vs. $2.00 per page. As such, clarity is needed. Clarity is also needed on the requirements of the verification form and what the charges are for a missed appointment and the record review.

Recommendation:

For the reasons indicated above, State Fund requests clarification on the proposed text regarding the reimbursement rate and the number of pages each rate corresponds to. State Fund further recommends clarification be provided as to what is required on the physician's verification form.

Discussion:

ML 201: *Comprehensive Medical-Legal Evaluation*
ML 202: *Follow-up Medical-Legal Evaluation*
For these sections, please refer to our comments made under ML 200: *Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation* regarding the potential issue with interpretation on the reimbursement rate and that clarity is needed on the requirements for the verification form.

Recommendation:

Please refer to our comments made under ML 200: *Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation* for recommendations.

Discussion:

ML 203: Fees for Supplemental Medical-Legal Evaluations

Please refer to our comments made under ML 200: *Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation* regarding the potential issue with interpretation on the reimbursement rate and that clarity is needed on the requirements for the verification form. Also, this section references costs associated with writing a report not an evaluation. The proposed text should say this.

Recommendation:

Please refer to our comments made under ML 200: *Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation* for recommendations.

State Fund also suggests a revision to the title of this section to provide an accurate description of the section: *Fees for Supplemental Medical-Legal ~~Evaluations~~ Reports*

Discussion:

ML 204: Fees for Medical-Legal Testimony
The proposed text for this section provides for a minimum allowance of billing amount for cancellations. To be consistent, it would be beneficial to instead provide for a maximum allowance of billing amount for cancellations.

Recommendation:

For clarity purposes, State Fund recommends the following revision:

If a deposition is canceled fewer than eight (8) days before the scheduled deposition date, the physician shall be paid ~~a minimum of~~ one hour for the scheduled deposition.

Discussion:

ML 205: Fees for review of Sub Rosa Recordings
There is a concern that documentation is needed to determine if a report is payable when a physician receives the sub rosa prior the issuance of a pending report. The propose text of this section is not clear on how to establish this.

Recommendation:

State Fund requests clarification for guidance on payment processing under this section.

Overall Recommendation:

To ease the payment process of these medical-legal bills while preserving the DWC's intent to reduce frictional costs and reduce the number of billing disputes over medical-legal fees, State Fund suggests having a separate code for record review only. This can be accomplished by adding another code that specifically is for medical review and providing an established rate for this. State Fund suggest the following code be added after ML 206 in this section: ML 207: Medical Record Review

In closing, State Fund thanks the DWC for the opportunity to provide input regarding the DWC's proposed amendments to the medical-legal fee schedule.

Thank you for taking the time to hear from each and every stake holder in the QME/ WC process. As a QME psychiatrist I agree with the rationale set forth by Dr. Gabor Vari. He outlines very important issues with the new fee schedule in comparison to other states and to various other issues.

As a psychiatrist/mental health specialist, I must provide a very comprehensive and nuanced evaluation, including an extended interview, careful review of the records and extensive psychological testing which must all be synthesized into forming fair and well reasoned opinions.

It is not fair to set forth a one size fits all fee schedule for all QME specialties as each specialty requires very different amounts of time for each aspect of the examination. For this reason, regular, non QME psychiatry outpatient follow-up appointments are usually allotted at least a 30 minute slot whereas primary care and orthopedic outpatient appointments may be scheduled every 10-15 minutes or so. Plain and simple, it takes longer to conduct mental health evaluations for a number of reasons.

In order to provide reports that provide substantial medical evidence, mental health care providers must be compensated fairly for our time. I respectfully request that the current QME fee schedule remain in place for mental health specialists. If that is not an option, we should be provided with a separate fee schedule taking into account the unique and complex evaluations we do which inherently require more time than other QME specialties.

I again thank you for your attention to my comments on this matter.

Peter Bullock MD MBBS QME July 10, 2020

I am writing to you as an interested party in the current proceedings before the Department of Workers Compensation(DWC) concerning the Medical Legal Fee Schedule. I have been a QME for 26 years and I am a former President of the California Society of Industrial and Surgery(2007). The number of active QME's has been gradually decreasing over the past 5 years as a direct result of factors significantly associated with decreasing reimbursement which has directly affected the care of injured workers. In my practice I am reviewing other's QME evaluations of my patients and as a treating physician I am having to clarify and correct these QME reports by dealing with the Rating Bureau. What a situation! This is injurious to the workers.

It has been an incredulous 14 years, FOURTEEN YEARS, since the DWC increased the reimbursement for Q.M.E.s (Qualified Medical Examiners). QM E's are an

increasingly small group of generally older physicians who are the final arbiters of injuries incurred by injured workers. QME's are re-appointed annually by the State of California by way of the Department of Workers

Compensation. They are a mixed group of MD's including every medical specialty such that the Rating Bureau of the owe must be able to generate ratable reports in order that Applicants receive the benefits accorder them by law.

Over this past year there have been multiple discussions over QME fees between the three main parties, the Physicians, the Insurers and the DWC. To put things in perspective the DWC is by law the "neutral" party and takes evidence from both the remaining two parties, i.e the Physicians and the Insurers. As you can imagine the Insurers are very strongly represented by legal defense and the physicians/MD's generally have acted on their own behalf or as part of a Medical Society. One such society is the California Society of Industrial Medicine and Surgery, CSIMS, which is a smaller group of physicians whose raison d'etre has been the health/treatment and wellbeing of injured workers.

Given these gross inequalities one should imagine that the Physicians would have been outdistanced by the Insurance Industry. However over this past year, there has been a very spirited, factual presentation by the Physicians/CSIMS in support of the appropriate MLFS {Medical Legal Fee Schedule) dollar increases and much of what they presented to the DWC was irrefutable. For example the **QME's have been dealt out of any increases** in violation of the administrative law as follows. The code is unambiguous in that also **QME's may ask for increases over and above the fee schedule** which is published !

Labor Code 5307.G{a) states the following;

"(a) The administrative director (AD) shall adopt and revise a fee schedule for medical-legal expenses as defined by Section 4620 , which shall be prima facie evidence of the reasonableness of fees charged for medical-legal expenses at the same time he or she adopts and revises the medical fee schedule pursuant to Section 5307.1 .

The schedule shall consist of a series of procedure codes, relative values, and a conversion factor producing fees which provide remuneration to physicians performing medical-legal evaluations at a level equivalent to that provided to physicians **for reasonably comparable work,** and which additionally recognizes the relative complexity of various types of evaluations, the amount of time spent by the physician in direct contact with the patient, and the need to prepare a written report." **{emphasis added)**

At one point within this last few months during ML fee visitation the physicians were pushed into a position whereby the Insurance Industry had pressured the DWC to make the Physicians accept what was a seriously defective fee increase and was only accepted because the Physicians were exhausted, having practices to care for as well try to negotiate a new fee schedule for all the QMEs in the State of California. Having agreed to a resolution the DWC then suddenly after agreement, reneged upon many of the issues with the complicity of the Insurance Industry (who must have felt they were not getting what they wanted and wanted more). What now becomes clearer is the function of the DWC is controlled or grossly influenced by the Insurance Industry (reference the QME scandal of the Underground Regs). That agreed fee schedule was not appropriate.

So at this point the Physicians are left with attempting to resolve this matter with a minimum of friction.

The regulations as averred to above required the DWC to, at specific intervals, review and revise the fee schedules but they have not done so for reasons which are now clear; the DWC is thought to be the pawn of the Insurance Industry. So it requires the Physicians to come up with a reasonable plan in accordance with the code.

See supra"The schedule shall consist of a series of procedure codes, relative values, and a conversion factor producing fees which provide remuneration **to physicians performing medical-legal evaluations at a level equivalent to that provided to physicians for reasonably comparable work, and which additionally recognizes the relative complexity of various types of evaluations,** the amount of time spent by the physician in direct contact with the patient, and the need to prepare a written report."

I **am advised that between 2014 and January 2020, the OMFS was updated over 60 times (https:// ww w.dir .ca.gov/ dwc/ OM FS9904.htm) by the Administrative Director. During that same time period, the Administrative Director updated the medical-legal fee schedule zero times despite being required to do so regularly by statute.**

Had DWC updated the medical-legal fee schedule regularly, **as required by law,** (see supra) then QMEs would be reimbursed much more reasonably today and we would not be in this scuffle. In contrast to the medical-legal fee schedule, the DWC annually updates the Statewide Average Weekly Wage in order to ensure that injured workers are receiving appropriate adjustments to their financial benefits. SAWW increased from $838.42 in 2006 to $1,325 in 2020. Therefore, **financial benefits for injured workers increased 58% during the same time**

period that QMEs saw no increase whatsoever. This failure to act in accord with the statutes was wrongful and intentional conduct. Why were the QME's excluded ? However based upon the SAWW increase of 58% that would not be unreasonable **under the statute to extrapolate to the MLFS**

*The **reasonable hourly fee** for the services performed by QME's taking into consideration comparable work by other physicians in private environments within the Bay Area who have been given the reasonable increases appropriate under COLA is a minimum of $395.00 per hour. For Psyche it should be a minimum fee of $750/hour. This will be shown by further hearing and evidence presented by Bay Area physicians. We must simplify the process. A 58% (supra) increase of $250 per hour is $145 add to $250 current fee= $395/hour. Now we are on par with common sense and the SAWW and we would be on par with the DWC except for external pressure-mongers

The nonsense about page counting is intolerable and silly to highly trained professionals who are post graduately trained and must be eliminated. It is too complex, time wasting and violates the code 5307.G(a). If the payors do not like what is being presented then they need to sever the association they have with the DWC and present their own controversial evidence. They have none. Physicians will not beheld up as crooks and ne'er do wells nor engage in this ridicule of their profession by Insurance Groupies who act unknowingly and out of ignorance for what QME's stand for and who do a great service in the communities they serve.

It is my request that were-open a hearing for physicians in accordance with the Code above to fully present their evidence. This is based upon the failure and covert behavior of the Insurers following agreement in persuading the DWC to forward **a new fee schedule** that is designed to entrap and harass the physicians after the physicians good faith negotiations. A new hearing must be permitted as a result by law.

Concerning the issues of the ML104 billing code. This has raised the ire unnecessarily of the Insurance Industry. ML104 is used for complex worker injuries. It is a good code in that it is a necessary code because complex or multiple injuries require multiple evaluations within the report. I can think of many more reasons we need this complex report code. Without this code injured workers will be short changed in the rating reports of QME' s. It is that simple. If the employer does not like the billing code they can appeal the billing through the provisions of LC 5307.6(b) (see infra) Eliminating this code will cause untold of harm to the workers and further raise the frustration and ire of QME evaluators. Again **"if it ain't broke stop trying to fix it".**

This is also covered by the administrative code 5307.6(b)

"(b) A provider shall not be paid fees in excess of those set forth in the fee schedule established under this section unless the provider provides an itemization and explanation of the fee that shows that it is both a reasonable fee and that extraordinary circumstances relating to the medical condition being evaluated justify a higher fee; provided, however, that in no event shall a provider charge in excess of his or her usual fee. **The employer and employee shall have standing to contest fees in excess of those set forth** in **the fee schedule."**

What could be more appropriate or easy for the Insurer or QME

Has anyone in the DWC read a Psyche QME of 20-50 pages or examined the complexity of the issues that are evaluated. To those of us who have it is a language that few of us understand but it is a time consuming and mandatorily so to properly evaluate psychological and psychiatric disorders. How could a factor of less than 2 be inappropriate. I would be pleased to demonstrate the complexity by pulling from my files a psych report for the DWC to review appropriately decaptioned in support of this request. Again the Insurer is fully **covered by LC 5307.6b supra** if they have reason to doubt any part of the report; eg the bill. At the hearings in Oakland, this was "disposed of' within a 20-25 minute time span giving Psyche evaluators no input. The opportunity to be appropriately heard is a substantial due process issue and was denied this group. It had to be hidden on the agenda somewhere but the Physicians present apparently had no notice of this having been agenized but someone knew !!

Dealing with the issue of ML104 and Psych reporting, no-one has raised the issues that these reports have to also conform to SUBSTANTIAL EVIDENCE within the terms of the WCAB. This in and of itself brings in multiple factors mandating a means to do it properly. The ML Schedule is good in its layout. Dr Rick Newton spent many hours with all Parties a longtime ago and we had agreement. Now all the MLFS needs is the fair increase for all QME's and Psyche should be reasonably a minimum 2x modifier on the $395 calculated above*.

The Legislature is aware of this crisis. AB1832 (2019-2020) was designed to correct the MLFS fee deficit but again the Insurance Industry was able to "get to" Committee Members and shelve it.

AB 1832, as introduced, Salas. Workers' compensation: medical-legal expenses.

The bill stated that this was an urgency bill as follows "This bill would declare that it isto take effect immediately as an urgency statute."

"The bill would require the administrative director to **increase the conversion factor quarterly.** as necessary, to reflect any increase in the Bureau of Labor Statistics Consumer Price Index for medical care, as specified. The bill would also require the administrative director, on or before January 15, 2020, to assign a reasonable relative value, greater than zero, for a missed or failed appointment for a comprehensive or follow-up medical-legal evaluation and for a review of medical records associated with a missed or failed appointment." (**emphasis** added)

None of the above is foreign to the DWC !As can be seen there is some spit and polish needed to clarify past omissions and this should be by hearing.

This letter is submitted as an attempt at a primary and early resolution to stop the **unworkable manner** in which a new MLFS fee schedule has been assembled, re-assembled and re-presented by the INSURANCE Industry in a manner that can never be acceptable to our professional QME Physician. The majority of QME Physicians are going to resist the unfair manner, violate of law, in which they have been relegated to second rate professionals. We hope that now the opportunity can be grasped by the DWC to sever its unfair practices and recognize that this is the time to undo all the mal-contentedness within the QME industry.

Sandi Bare July 10, 2020

I have worked for doctors who do medical-legal evaluations in Workers' Comp for several years, and have more recently been working with a highly experienced and well-regarded Qualified Medical Examiner and Agreed Medical Examiner in Psychiatry practicing in Southern California.

As proposed, this prohibitive fee schedule would mean that the psychiatrist I work for would be unable to produce the kind of reports needed by Workers' Compensation. Without being fairly compensated for the doctor's time on an hourly basis, like other psychiatrists and psychologists, like the lawyers with whom the doctor works, and like other professionals, the doctor would no longer be able to work as either an AME or as a PQME, and I would be out of a job.

The doctor pointed out Labor Code 5307.6 to me. It's stated that doctors should receive "…fees which provide remuneration to physicians performing medical-legal evaluations at a level equivalent to that provided to physicians for reasonably comparable work, and which additionally recognizes the relative complexity of various types of evaluations, the amount of time spent by the physician in direct contact with the patient, and the need to prepare a written report."

This flat fee schedule is impractical, confusing, open to misrepresentation and misinterpretation. Ultimately, it is unworkable. I would understand that, for psychiatrists, instead of a raise, this would be a major decrease in payment, where the doctor fears having to close the office.

I appreciate the opportunity to comment upon these changes and express my concerns for the far-reaching consequences of this proposal.

Dr. Naren Gurbani, M.D., FACS, FAAOS,QME July 10, 2020

After a thorough review of the proposed changes of MLFS, I must say I am very disappointed. Our collective goal must be to provide a quality evaluation report to all parties in a timely manner so that injured worker can get medical/financial benefits and return to work as soon as possible. In the process, QMEs deserve to be fairly compensated for their time and expertise.

To accomplish this goal, I am proposing the following solutions to correct the deficiencies.

1) All records including Sub Rosa recordings must be received by QME office at the least two weeks prior to Date of Evaluation in order to be included in the report. Any subsequent records will qualify for a Supplemental report.

2) Submitted records must be in chronological order with certified total count at the top. QME is entitled to be compensated for all pages out of chronological order at the rate of $1/page.

3) Page size must be 8x11", double spaced with minimum font size of 12 and single sided.

4) Number of pages in excess of first 200 for Initial evaluation and 50 for supplemental report must be reimbursed at the rate of $3/page.

6) Reevaluation fee schedule must be valid up to 9 months from the Initial evaluation date.

7) Missed and cancelled appointments as defined must be compensated at the rate of 50% of initial or reevaluation flat rates.

8) ML 206 must be redefined as Unreimbursed Supplemental Report.

9) Depositions must be reimbursed for minimum of 2 hours.

10) COLA must be applied to all QME fees en par with DWC employees.

I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. General reimbursement levels and terms agreed upon must be honored by DWC.

In my opinion, Medical-Legal Fee Schedule proposed by Sue Honor, the former manager of the DWC Medical Unit not only modernized reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

The fact that DWC has disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the proposed reimbursement is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

As you know, the total number of QMEs has dropped significantly and requests for their services have gone up sharply. If meaningful changes are not adopted as described above, the crisis is bound to get worse.

Mark Miculian,MBA PhD July 10, 2020

I was disheartened at the proposed rate changes for psychologists and psychiatrists. QME evaluations are complicated and require much thought and careful crafting to produce a useful report that is fair to all parties involved. This complexity is recognized by the fact that mental health examinations must be a minimum of 60 minutes while other practitioners have a 20-minute minimum. (In the far majority of cases my examinations are at least three hours to address the required issues.) Given this ratio, **a modifier of at least 3.0, would be more reasonable for all psychiatric and psychological reports.**

Use of a COLA provision, may slow the loss of available QMEs at a time when the number of QME panel requests have increased. Compared to 2006, the buying power of a dollar in 2020 is worth 25-30% less. Yet, wages, taxes and other expenses have increased. https://www.bls.gov/data/inflation_calculator.htm

While I enjoy the challenge of these evaluations, I am unsure if I would continue as a QME with the proposed fee schedule. I already under bill for the hours used in many of these evaluations. I know many good psychologists already who do not do these evaluations because they are time-consuming and complicated; they can make more money elsewhere.

Juan Realyvasquez July 10, 2020

I have devoted my life to orthopedics in that I have been teaching for over 35 years. I began doing qualified medical evaluation's two years ago. I found was disappointed with some of the ways that the workmen were cared for. I find that your new recommendations take away from fthe Worker. This is especially prominent in psychological problems.

Many of the workers are Hispanic and many have come to this country to improve life. They take jobs add and get less pay and offer don't get insurance to cover their illnesses and their family. They have a problem language and are often afraid of speaking up because they fear the loss of their job.

Do you DWC has looked at not reimbursing for records review. I really recommend a discharge be done. This will result in incomplete reports.

The DWC was started to improve the work conditions of California workers. In the limited time that I have been evaluating patients, I find that there are injuries that are overlooked or treated as minor injuries. Many of the company associated Workmen's Compensation doctors favor the employer. It is the employer or insurance company that benefits the most.

Julius Young July 10, 2020
Boxer & Gerson LLP

The Med-Legal Fee Schedule regulations need more work and should not proceed to rule making in their current form. The DWC needs to do more to assure that there is a well-functioning QME system. Without that, both workers and payors will suffer a decline in QME availability and report quality.

My assessment is set forth in a post published on my workerscompzone.com blog, which I am copying here as a comment for the forum:

The California Division of Workers Compensation’s latest proposal to amend the QME fee schedule needs work.

If the DWC does not revise the proposal unveiled in June 2020 for public forum comments, the QME system, injured workers and payors will be adversely affected.

As I finished this blog post, there were hundreds of pages of comments on the forum (see link below) with the ratio of opponents to proponents probably 10-1 among those posted to the forum as of July 7.

What is at issue, why is this important, and why such opposition?

California QMEs, who evaluate injured workers to make determinations on injury and disability causation and disability assessments, have not had a fee adjustment since 2006.

Over time the pool of QMEs has shrunk. In many QME specialties there are insufficient numbers of evaluators. There has been increasing concern about report quality, but round after round of workers' comp reforms and developments in the law have resulted in increasing complexity of the factual and legal issues in many of the cases. QMEs are being asked to do more analysis and documentation.

Think about it. Case law requires attention to the "how and why" of medical opinions in order to satisfy the substantial evidence standard. Cases such as *Rolda* (psyche injury causation), *Escobedo*, *Gatten, Benson , Rice/City ofJackson* (apportionment), *Almaraz* and *Guzman* (rating PD), *Hikida (*compensable consequence and PD issues), *Dahl* (amenability to rehabilitation) and many others involve intermingled complex factual and legal issues.

The system will not have quality reports unless the doctors who evaluate are adequately paid. You get what you pay for.

How often have I heard defendants whine about shoddy reports from QMEs that lack attention to detail, explanations for conclusions, and in-depth analysis!

Yes, they appear to largely be on board with this fee schedule which will encourage such reporting.

While some may argue that there has been a problem with QME billing (undoubtedly true in some cases) causing a need for aggressive oversight, many QMEs have complained in recent years of what appeared to be a campaign to harass examiners. QME unhappiness and the aging of QMEs has led to continuing dwindling of the QME pool.

How much does the current QME system cost? According to a recent WCIRB report in calendar year 2018 the costs were $280 million and 2019 were $290 million. In 2019 Med-Legal costs were 11% of total medical services and 6.3% or total paid medical.

Many of these issues came to a head when the California State Auditor prepared a scathing 2019 audit report critical of the DWC's administration of the QME program (see link below).

Meanwhile, for several years the DWC was looking at adopting an alternative scheme to compensate QMEs. This included a 2018 DWC forum, various 2018 and 2019 stakeholder meetings, and an August 2019 proposed fee schedule amendment which went nowhere after a massive outpouring of opposition. Yet more stakeholder meetings were held in late 2019.

Representatives of many of the California stakeholders (including employers, insurers, individual doctors, physician groups and attorneys) attended an early January 2020 meeting, and some felt there was progress towards agreement on a new fee schedule. Alternatives were discussed and some points of agreement noted on a blackboard. However, there was no formal agreement drafted although some bullet points were circulated. A follow-up meeting (which I attended) in late January 2020 resulted in consensus on some issues, but there was notable dissent on several issues, and the meeting stopped short of dealing with other thorny issues. There was no post-meeting statement of agreement circulated.

I realize that some physicians are under the impression there was "an agreement", but that may be a bit naive.

It's unclear exactly what maneuvering has occurred since the January 2020 meetings, but it seems that payors grabbed the DWC's ear. Thus, DWC unveiled their proposal for forum comments (see link below to the June 2020 DWC proposal).

The DWC proposal provides for a flat fee system for evaluations and reports and reimbursements for medical record reviews based on page count of records reviewed. A complexity multipier modifier is dropped, although cases with interpreters, AME evaluations, and some medical specialties receive slightly higher multipliers than the basic evaluation rate.

If adopted in the form as unveiled in June 2020, there would be QME winners and losers. Winners would be QMEs evaluating relatively uncomplicated cases such as uncomplicated orthopedic cases without a large volume of records. Losers would be QMEs evaluating complicated injuries with a large volume of medical records, difficult apportionment issues, involved body parts, vocational feasibility issues, etc etc. Losers would also be psychiatric and psychology QMEs and internal medicine QMEs who have large volumes of records to review and complicated histories to sort through.

As set forth for forum comment, the proposal includes a number of goofy ideas:

•the rate for reviewing medical records past a 2,000 page count is reduced from $3.00 per page to $2.00 per page, which seems to assume that reviewing gargantuan stacks of records is less demanding

•the regs define a ML 202 as a follow-up if occurring up to 24 months past an initial evaluation. Currently it is defined as 9 months. Given how quickly medical situations of workers can change, 24 months is a poor timeframe choice . The lower payments will discourage adequate re-evaluation of emerging and changing worker conditions and disabilities.

•the QME is charged with counting the number of pages submitted by the parties, adding another burden that should be placed on the party submitting the records for review

•a provision for a “remedial supplemental evaluation” category provides QMEs insufficient assurance they will be paid and provides too much opportunity for manipulation by payors. The provision seems to allow a payor to refuse to pay for a supplemental report where it contends that the issue was or should have been addressed. In the real world, parties often seek supplemental reports as they seek to work with the facts and the complexities of the case law. Moreover, in the real world, QMEs often receive incomplete information and records and other data are sent piecemeal for the QME to analyze. This section alone, which lacks sufficient guardrails, would be enough to reject the current proposal.

Other problems with the proposal include the following:

•despite the recommendation of the State Auditor, there is no provision for a COLA for QME payments

•the fee multiplier is too low to compensate psyche examiners, internal medicine examiners and some of the other specifies who are asked to evaluate many of the most complicated cases

•the proposal seems to do nothing to increase report quality

•the proposal does nothing that will attract physicians to become QMEs; quite the opposite, a number of commenters noted that they may surrender their QME license if the proposal is adopted. It is as if the State Auditor report was ignored.

While there are some bright spots in the proposal (for example, a schedule for compensating for missed appointments, a multiplier where interpreters are involved, a payment schedule where physicians review sub rosa videos, a a schedule for deposition time compensation), those are insufficient reason to adopt this proposal.

More stakeholders meetings should be held, as well as a live public forum on any tentative proposal.

Franklin Carvajal, Ph.D. July 10, 2020

I just began doing QMEs this year as a psychologist. I can tell you that these evaluations are much more complex and annoyingly fastidious compared with any other evaluation I do. I do all types of forensic evaluations: Incompetent to stand trial, MDO, NGRI, SVP. I have also conducted extensive assessments for children and adolescents (ADOS, Vineland, WISC, etc). I can tell you for a fact that these evaluations take wayyyyy more time than anything else I do. So, let me ask you a question: why would I bother to spend my time doing this when I can easily have less stress, be equally professionally satisfied, and make equal or more money? As a psychologist, there are tons of things I can do! I do not think it is much to ask for you to simply pay a fair amount for the long and time consuming QME reports.

Basil Besh, M.D. July 10, 2020
Past President
California Orthopaedic Association

Michael Klassen, M.D.
First Vice Presient
California Orthopaedic Association

The California Orthopaedic Association appreciates the Division moving forward with an update to the Medical-Legal Fee Schedule.COA and its 2,000 members support the fee schedule being based on a flat rate system, as we believe this change will reduce friction, streamline the system, improve communication between the parties, and improve the quality of reporting. All good outcomes for stakeholders, and most importantly, for the injured worker.

We also appreciated being part of the stakeholder Work Group. It was a collaborative discussion with compromises being made by all parties to reach consensus on the issues and move the discussion forward. The Division has deviated from the Work Group’s proposal in important ways which upsets the balance of the negotiated agreement. Attached is a list of issues that need to be addressed.

We feel that the Work Group, comprised of Workers Compensation payors, self-insured employers, defense attorneys, applicant attorneys, physicians, and medical-legal management companies, came together to propose changes that were fair and agreeable. We urge the Division to adopt all of the recommendations of the Work Group.

Enclosed letter:

The California Orthopaedic Association represents over 2,000 orthopaedic surgeons practicing in California. Many of our members treat injured workers and serve as Qualified Medical Evaluators (QMEs) and Agreed Medical Evaluators (AMEs).

Thank you for the opportunity to participate in the stakeholder Work Groups which were charged with recommending changes to update the Medical-Legal Fee Schedule. It was a collaborative discussion with compromises being made by all parties to reach consensus on the issues and move the discussion forward. We feel that the Work Group, comprised of Workers Compensation payors, self-insured employers, defense attorneys, applicant attorneys, physicians, and medical-legal management companies came together to propose changes that were fair and agreeable.

COA and its members support the flat rate system.

As you know, the flat rate system is based on a series of levers, designed to adopt the recommendations of the State Auditor – to update the fee schedule by at least 30% to adjust for a cost-of-living increase over the last 12-13 years when the fee schedule was not updated. The current hourly QME rate is $250 per hour. A 30% increase brings the hourly rate to $325.

When you, adjust one lever (e.g., propose to reimburse review of records at $2.00 per page rather than the agreed upon $3.00), you also need to adjust other levers, (e.g., increase the flat rate fee) to maintain the agreed upon hourly rate for physicians.

Payors wanted to stay at the $325-$350 rate per hour. Physicians argued for $400 per hour to adjust for cost-of-living increases and to give them a raise to evaluate the truly complex cases. We felt that the reimbursement to AMEs under this flat rate system, could be drastically reduced and they would no longer be willing to take on the most difficult cases. In the end, physicians compromised and agreed to see how AMEs faired under the flat rate system.

We urge the Division to go back to the consensus of the Work Group and set the AME modifier at 1.25% - across-the-board on the evaluation and record review.

Other Issues we urge the Division to include in the proposal:

1. An automate cost-of-living increase. The Division adopted an automatic cost-of-living increase for the Official Medical Fee Schedule (OMFS) – Physician Services – the Treatment Fee Schedule based on the Medicare Economic Index (MEI). MEI is adjusted each year to reflect changes in the cost of running a medical office. They are generally modest adjustments, but at least the fee schedule is routinely updated. No cost-of-living increase is included in the DWC proposal. Without an automatic annual cost-of-living update, the fee schedule will again be dated by 2021.

We urge the Division to adopt the automatic Medicare Economic Index (MEI) adjustment each year for the Medical-Legal Fee Schedule as they have done for the OMFS.

2. **Missed Appointments –** we agree with the Division's recommendation for when a Missed Appointment is reimbursable. In addition, not discussed by the Work Group, if an interpreter does not show up on time, the evaluation may also not be able to be held that day. This is also beyond the control of the physician.

We urge the Division to include interpreters in the definition of a missed appointment. We would suggest the following language – "Includes instances where the injured worker or interpreter, if applicable, the injured worker or interpreter is more than 30 minutes late for the appointment…."

Overall, we believe that this new flat rate system for the Medical-Legal Fee Schedule will make a significant difference in removing friction, improving the quality of reports, and holds everyone accountable if they do not perform. All good outcomes for the injured worker.

Implementation date of the Fee Schedule. The stakeholders have been waiting a long time for these changes. When the discussions first began, participants were envisioning a July 1, 2020 implementation date. With COVID-19, we understand it has been impossible to stay on that timeline, however, we would urge the Division to implement the changes as soon as possible. We would hope that an October 1, 2020 implementation date would still be possible and make that recommendation.

Thank you for considering these comments and additional changes to be consistent with the recommendations of the stakeholder Work Groups.

Cyrus Riahi Ph.D. July 10, 2020

I'm writing to you regarding the new proposed QME fee schedule.

I think this proposal is a good first step in the right direction. However I think inclusion of 200 pages of records in the flat fee is unreasonable. I believe it should be reduced to 50 pages. I also think COLA increases should be included in the new contract. I thank you for considering my suggestions.

Sanjay Deshmukh July 10, 2020

I have reviewed the proposed new fee schedule for AME evaluation. Please note this reduction will negatively impact my and my fellow QME providers. The cost of practicing medicine is increasing. The reduction in reimbursement will hurt providers. I feel we will lose good providers which will effect the system negatively. Please reconsider the changes. I feel many providers will no longer practice and this hurts the injured workers, insurances and employers.

Dana Levy, M.D. July 10, 2020

I am a QME in Psychiatry and am writing regarding the proposed fee schedule changes.

While I can appreciate the idea that fixed fees could “reduce frictional costs”, the proposed fee schedule changes grossly underestimates the amount of work ***required*** of mental health evaluators.

I will go into detail later regarding how/why the proposed 1.5 Psych modifier is completely inadequate; but the take-away point needs to be that in respect to the actual time and work required of a Psych QME, the proposed fee schedule would make it not cost-effective to continue as a QME.

> **POINT #1A: The psych modifier needs to be at least 2.5 to 3.0; and if at the lower rate, should include additional modifiers such as 0.5 for Rolda and 0.5 for any past psych claims**.

The Physicians Guides and the regs make it clear that evaluation of a Psyche injury (compared to a Non-psych injury) requires the exploration and discussion of many more areas of consideration, in a much greater level of detail and with additional complexities to produce a QME report that is of substantial medical evidence. The history a Psyche QME is mandated to obtain must explore many areas in great detail, resulting in quite lengthy in-person evaluation (as well as a lengthy history in the report to document the enormous detail that was covered). The in-person portion assessment of a Psych injury in a native English-speaking applicant typically requires 3 hours in face-to-face. Evaluation of applicants with bonafide mental health diagnoses can take even longer,

such as up to 4 or 5 hours depending on the degree of impairment. The Guides/Regs also require a Psych to address many areas of complexity that are not required in the assessment of non-Psych injuries. Altogether the time required to perform the work involved in a Psych QME assessment (as required in the Guides/Regs) will not be adequately compensated by a 1.5 modifier.

POINT #1B: The psych modifier should apply not only to the base rate but also to record review.

First, the content of the records in applicants with psych injuries is frequently more dense including past psychiatric records, personnel records and other documentation. More importantly, the regulations even hold psych QMEs to a higher level of record review than other specialists, requiring them to review records personally**, which further warrants the psych modifier being applied to record review as well as the base rate.**

The is not a light complaint that being a Psych QME would become akin to a poorly-paid community provider; rather it is a statement that the proposed fee schedule is so inadequate that continuing as a Psych QME would be so impractical it would essentially force me to delist.

I have spoken to quite a few colleagues about this and I am not the only Psych provider who found the proposed reimbursement vs. time/work ratio to be completely inadequate. Many were moving towards a similar conclusion that it would not be cost-effective to be a Psych QME under the proposed fee schedule.

Beyond the debate between the needs of the payor and the payee, I do hope the DWC is considering the potential damage the proposed fee schedule could have on the injured worker.

If it is not cost-effective to be a Psych QME, the loss of QMEs could potentially harm the injured worker due to increased delays/barriers in an already difficult QME system. As a reminder, Psych claims in particular are almost always denied initially, such that Psych QME evaluations are necessary for an injured worker to obtain access to treatment. At minimum, a more difficult QME system would hinder and delay an injured workers access to care. But at worst, a more difficult QME system could effectively block injured workers access to care due to being so problematic/delayed that a worker loses hope of ever getting help and gives up.

One cannot help but see how having less or even blocked access to treatment, while quite detrimental to the injured worker, could be of great benefit to insurance companies.

I would point out that workers with bonafide Psych injuries are actually much greater risk for the extremely negative outcome of being blocked from access to treatment - due

to the nature of having a Psych injury. It would be easy to see how an injured worker with depression, if feeling hopeless or doomed would be quick to view seeking treatment as futile and "give up" if encountering many difficulties/delays. Or if severely depressed, a worker maybe fully taxed just keeping up with basic functioning and thus have no "extra" effort/persistence that might be needed to advocate for getting evaluation/access to mental health treatment and thus end up effectively "blocked" from access to mental health treatment.

POINT #2A: The rate at which an evaluator can perform a record review does not change based on how many records are provided; as such there is no logical basis for a variable per-page reimbursement for record review.

In regard to review of records, the proposed fee schedule changes are lacking in logic. The DWC proposes that record review for pages 201-1800 should be compensated at $3 per page and then $2 per any page beyond that. The drop in reimbursement for pages over 1801 has no logical justification. Does the evaluation/processing of medical records suddenly become easier or more efficient after 1800 pages? Perhaps if the reimbursement per page is decreased, then the amount of attention/effort required of the QME is supposed to decrease as well? Should the QME identify which records were of the 1801+ group, such that all parties know which records were assessed more limitedly in concert with the reduced $2/page reimbursement? None of this makes sense.

POINT #2B: If the DWC intends to transition to a per page reimbursement for records, then it should be based on a more common understanding that an evaluator can process about 100 pages per hour, and as such, to be consistent with the new RV that is being proposed, the rate for record review should be $3.25 per page.

The currently proposed fee schedule ultimately results in a ***decrease*** in QME compensation for review of records. It is common to consider that records can be reviewed at a rate of 100 pages an hour. At the rate of $3/page, the resulting hourly rate would be $300/hour, falling short of the proposed "raise" from DWC of a recognized billable hourly rate of $325. Worse yet, the $2/page reimbursement proposed for pages 1801+ would result in an hourly rate of $200/hour – far from a raise as this would be a $50/hour decrease from the current rate of $250/hour.

Another problem in the proposed changes is the DWC suggestion that ANY records received before the report is *submitted* MUST be included in the report. Again, there appears to be a lack of rational thought behind this change as it sets up the QME to be faced with unreasonable and impossible burdens. If an evaluator, finalizing their report on day 27 was to receive 800 pages of records just prior to putting it in the mail on day 28, the QME would be faced an *unreasonable* demand to somehow cram in 8 hours of work unexpectedly into 2 days to avoid submitting a non-compensated late report or to avoid producing a supplemental report for 800 pages of records for free because the

records happened to arrive just before the report was submitted. Or if there were 2,000 pages provided at the last minute, the QME would face an ***impossible*** situation of having less than 2 days to somehow complete an unexpected 20 hours of work.

A more logical requirement would be to support the QME in providing a comprehensive quality report would be having access to the medical records BEFORE the evaluation, at least 2 weeks prior to allow the doctor time to review the records for any areas/issues that must be addressed with the injured worker during the evaluation.

If the DWC does not wish to require records be provided in a timely way before the evaluation to provide the QME with access to everything needed for the most comprehensive and accurate interview and exam, **then**

> **POINT #3: at the very least the cut off for providing records should be the day of the evaluation. And any records received *after* the date of the evaluation should be considered a reimbursed supplemental report.**

A period of 24 months is far too long to be considered a re-evaluation. The amount of records can be extensive. More importantly, the evaluation of a psych injury continues to require a detailed exploration of the same many areas as in the initial evaluation to show a similar status or discuss any events/changes in the interim. Some workers are still suffering ongoing exposure to the claimed industrial stressor in an interim, requiring discussion and documentation in detail of numerous events of an ongoing continuous trauma. It would be possible that the number of negative events in 18-24 month interim are more than in an original 1 year CT period. **POINT #4: Extending the re-evaluation period to 24 months is not acceptable; there is too much interim information to be assessed to be paid at the lower re-eval rate. Even the current fee schedule recognizes a nine month cut off for re-evaluations.**

The remainder of this letter is the much more detailed discussion of many reasons why the proposed fee schedule with a 1.5 psych modifier is inadequate for the time/work required of a Psych QME; and instead **(POINT #1A): The psych modifier needs to be at least 2.5 to 3.0; and if at the lower rate, should include additional modifiers such as 0.5 for Rolda and 0.5 for any past psych claims**.

One need just review the State of California's, DIR DWC Physician's Guide to Medical Practice in the California Workers' Compensation System 4th edition 2016 to understand this.

To begin, the difference in what needs to be considered to identify whether or not an injury is "work-related" is vastly different between Psych injuries and non-Psych injuries.

1. In just 3 sentences, the 2016 Guide explains how a non-Psych injury can be considered "work related" if work events have (some/any) contribution to the injury, as work events need not be the sole nor even a primary cause of injury. In

contrast the 2016 Guide dedicates most of a page to discussing causation of psychiatric injuries, including how the threshold needed to be met for causation of a Psych injury, as per LC 3208.3, is a much higher than for physical injuries, plus many other exemptions that require consideration and additional exploration in the assessment of causation:

2. For a Psych injury to be work related, events of employment must be the predominant cause (more than 50%) among all the combined causes of the psychiatric injury.
3. Psych QME's must assess if the psychiatric injury resulted from being exposed to or victim of a violent act. The PQME must address whether or not this rose the threshold of "substantial cause", explained as at least 35% of the causation from all sources combined.
4. Claims of Psych injury when employment is under 6 months is prohibited except for cases of sudden extraordinary employment conditions. If this exemption is claimed/indicated, it must be evaluated in detail by the Psych QME to explain why the event was/was not sudden/extraordinary
5. Psych QME's must assess if "lawful, non-discriminatory, good faith personnel actions" contributed to the Psych injury and to what degree, as Psych injuries that are "substantially" (at least 35%) caused by "lawful, non-discriminatory, good faith personnel actions are prohibited.
6. Claims filed after notification of termination or layoff are prohibited, however there are exemptions. If claim was filed after notification of termination then the Psych QME must still assess whether or not events of employment were the predominant (more than 50%) cause and whether or not any of the exemptions were met. Assessment of exemptions can require other review – such as review/discussion of whether or not there was evidence in medical records of the Psych injury prior to termination, if the injury was the result of sudden and extraordinary events (see above need

The 2016 DWC Physician's guide clearly recognizes the difference in the complexity between evaluation of Psych claims and non-Psych claims:

> "because workers' compensation psychiatric claims are subject to more restrictions and because psychiatric claims require the collection of many additional facts, the physician must take a much more detailed history when doing this kind of evaluation."

If this were not clear, the 2016 guide goes onto identify some of the areas a Psych QME must explore as part of getting this "much more detailed history":

> "The examiner needs to address issues such as the employee's developmental history, personal problems, job satisfaction, performance reviews, and reasons

for leaving other positions. A psychiatric history should include the employee's level of functioning in home, academic, and social settings."

The time/work required to fulfill these requirements of the 2016 DWC Physician Guides DWC are well beyond a 1.5 modifier.

Furthermore, the above list of areas are only some of the areas a Psych QME must investigate. Assessing whether or not work events could be considered a predominant (more than 50%) cause *among all of the combined* causes requires the Psych QME to look into all potential causes and indicate whether or not a risk factor or active stressor was found. While not an inclusive list, the following are many of the non-industrial areas that must be explored by a Psych QME as part of being able make an opinion of whether or not a work injury was a predominant cause *among all combined causes,* providing reasoning as to why the 1.5 modifier is a gross underestimate of the time/work required in a Psych QME evaluation:

- Prior History of work injuries – including prior physical injuries – degree of permanent impairment / impact and any associated Psych problems; or prior Psych injuries – assess if claimed a previously similar injury, assess degree of prior dysfunction and any on-going (pre-existing) psychiatric impairment);
- Personal Psychological History - if any prior diagnoses or treatment of any kind, getting details of dates / severity / symptoms etc.
- Familial Psychological History – any family members with known mental health diagnosis or treatment, and details as needed.
- Social History - assessing for history of or current stress related to personal life such as: this includes childhood history, developmental history, educational history including reasons for cessation/drop out, trauma/abuse history, history of significant romantic relationships (including dates, children, abuse, reasons for separation), history of loss, details about the health (emotional/physical) of loved ones (including spouse, children, parents siblings), loss of loved ones, immigration (related stress such impact on employment or deportations)
- Substance Use History – assessing for history of heavy / regular / excessive use of any substance, substance related treatment. Substance related problems (social, occupational, legal such as DUI); substance use during employment and detailed description of current substance.
- Occupational History – history of employment (jobs, dates, reasons for leaving/changing, prior injuries, prior terminations).
- Financial History – history of or current stress from finances such as bankruptcy, repossessions, creditors and financial distress related to claim),
- Legal History – history of or current stress from personal legal events (such as divorces, civil suits, legal involvement for vehicular collisions, arrests or incarceration) or any other work-related lawsuits (such as with EEOC).
- Medical History – history of or current stress related to health diagnosis (getting

details of diagnosis, severity and impact), surgeries, hospitalizations, accidents (vehicular, recreational, sports), head injuries or losses of consciousness.

While QME's assessing non-Psych injury do need to ask about these areas, their assessment can usually be much more limited to history as relevant to the specific bodily injury they are assessing. In contrast a Psych QME has to get many details of each reported event in an applicant's history to be able to assess whether or not something could have been stressful and had an emotional impact.

The above list did not address the exploration of the possible/claimed Industrial contributors to a psychiatric injury (please note the last 3 items are not required of QME's assessing a non-Psych injury):

- Details of applicant's work history with employer of the claim
- Applicant's personal, social, medical, mental health and occupational functioning at the start of employment
- A comprehensive and detailed description of the claimed industrial injury – most often a continuous trauma such numerous specific events must be discussed and considered in great detail along with specific detail of the onset/evolution of symptoms/impairments of the psychiatric injury as must be detailed for causation.
- A detailed investigation of personnel actions (including performance evaluations, changes in job duty/title/pay, disciplinary actions) is usually required as many cover letters cite the claim as denied/prohibited based on "lawful, non-discriminatory good faith personnel actions" and specifically request a Rolda Analysis.
- Details of any of the previously discussed exceptions/exemptions regarding causation – violent acts, sudden and extraordinary employment conditions, employment under 6 months, claims filed after termination, and above mentioned personnel actions.
- If physical injuries are present, an assessment of whether or not the psychiatric injury is derivative of (predominantly caused) by the physical injuries, and as needed a discussion of exceptions to LC 4660.1(c)(2) of violent act or catastrophic injury.

It should be noted different cultural/educational backgrounds have a much greater impact on the assessment of Psych injuries compared to non-Psych injuries. For example, an applicant's answer to when pain started in a body part is *not* typically impacted by their cultural/educational background. In contrast, an applicant's answer about when depression started is often impacted by their cultural/educational background. Many applicants understand "depression" to be a term used for people who are actively trying to kill themselves or are so symptomatic they cannot get out of bed to go to work. It is not uncommon for an applicant with this belief to report their depression as "starting" the moment they had to be taken off of work, but upon further

investigation/clarification they describe symptoms that increased over many months or years prior to becoming too impaired to work. Unlike QME's evaluating non-Psych injuries, a Psych QME may need to spend additional time stopping to assess/confirm the applicant's understanding to ensure an accurate reporting of symptoms is obtained.

Another difference in the assessment of Psych injuries and non-Psych injuries is how the applicant's symptoms/impairments can be assessed. Assessing the impact/impairment of a physical injury is usually more straightforward as areas such as strength, reflexes, range of motion, lab values, blood pressure, measurements on radiographic studies often have very standard values of "normal" versus "abnormal". In contrast, the assessment of the impact/impairment of a Psych injury is not as straightforward, where the assessment of "normal" versus "impaired" has to be personalized to each individual applicant. To understand if symptoms/functioning (observed/reported) are "normal" or at baseline vs. impaired, a Psych QME must not only obtain comprehensive detail of the applicant's current symptoms and functioning, but also an understanding of these same areas at "baseline" or pre-injury. For example, a female applicant, reporting spending 5-10 minutes on grooming and observed as having hair brushed and pulled back in a ponytail, wearing lipstick, and with short/bare fingernails could either A) have normal/baseline attention to personal grooming or B) be exhibiting a notable drop in personal grooming if her baseline was spending 30-45 minutes daily on hair/make-up - wearing hair down and styled with "full" make-up (foundation, blush, lipstick, eye liner, mascara) and usually having longer, polished acrylic nails (manicured every couple of weeks).

These areas are just additional reasons/explanation as to why the modifier of 1.5 is ***not*** sufficiently provide adequate compensation for the time/work required of the Psych QME. Again, t**he modifier for Psych should be 3.0, or at least 2.5 with additional modifiers of 0.5 for a Rolda analysis, and 0.5 for a history of past Psych including past Psych claims.**

K. Winter, Ph.D. July 10, 2020

I am also a psychiatrist. This is the first I have heard about the proposed QME fee schedule. As usual I never get any communications from the DWC on anything, despite my dutiful QME fee every year. I am in complete agreement with the letter from Dr. Stone and other psychiatrists. I will resign if these changes are implemented. I get worn out with the arbitrary denial of payment by the bill review companies, for invalid reasons. Anything that gives them more reason for denying payment will be used. It is pretty frustrating to devote 12 or more hours to an evaluation, and get it denied for some baseless reason, and make me jump through hoops to get it corrected. You need to

make any new fee schedule more friendly to the examiners and have it reflect an increase commensurate with the 14 years you have not increased the rates.

Please do your best to keep us informed on the final outcome of the fee schedule, so I can decide whether I will continue on the QME panel or not.

Denis Clegg, M.D. July 10, 2020

I am also a psychiatrist. This is the first I have heard about the proposed QME fee schedule. As usual I never get any communications from the DWC on anything, despite my dutiful QME fee every year. I am in complete agreement with the letter from Dr. Stone and other psychiatrists. I will resign if these changes are implemented. I get worn out with the arbitrary denial of payment by the bill review companies, for invalid reasons. Anything that gives them more reason for denying payment will be used. It is pretty frustrating to devote 12 or more hours to an evaluation, and get it denied for some baseless reason, and make me jump through hoops to get it corrected. You need to make any new fee schedule more friendly to the examiners and have it reflect an increase commensurate with the 14 years you have not increased the rates.

Please do your best to keep us informed on the final outcome of the fee schedule, so I can decide whether I will continue on the QME panel or not.

Dr. Cynthia Neal July 10, 2020

I am a clinical psychologist QME and have been since 2016. I am also a MDO evaluator for Department of State Hospitals in the California Department of Corrections and Rehabilitation.

I find the QME evaluations are complex and nuanced, requiring hours of thought and preparation in order to submit a product which will withstand the rigors of forensic scrutiny.

I will not be able to produce a quality product if the fees are reduced. I find the current fees barely adequate to cover the time and resources required to produce a quality product.

Therefore, if the current fee structure is reduced, I will be compelled to forfeit my QME standing, as I will not have my professional reputation compromised by the production of an inferior product.

Lawyers talk to each other and compare Doctors. I could not allow the production of an inferior QME product to compromise or besmirch my reputation in the legal community, and therefore compromise my MDO work.

I worked very hard to obtain my QME standing. I was told pass rates were in significant decline when I took my exam. I would hate to be forced to resign so soon after obtaining this credential.

Further, the lack of increase in fees for, as I understand, approximately two decades, has already compelled many QMEs to resign, as the work is often too labor intensive to be sustainable within the current fee structure. I most certainly do not want to be a causality of the current proposed decrease in fees.

Dr. Pirruccello July 10, 2020

I would ask that you please give consideration to a fair fee schedule for those of us who are performing QMEs.

Performing QMEs at a high level of clinical competency that includes giving our medical opinions with reasonable medical probability is an extremely difficult and important function that takes a considerable amount of thought and time.

In order to get the best physicians to do this important work for the State of California, it is only fair that we are reimbursed reasonably.

I ask that you give strong consideration to fair reimbursement for QMEs.

Eli E. Hendel, M.D. July 10, 2020
QME

Overall, I have positive thoughts about the proposed changes.

I have few concerns that may create misunderstanding in the future:

1. It is still not clear what is the deadline for the delivery of medical records that the QME will be responsible for in his report. As it stands now, the records nust be received by the evaluator within a maximum of 10 days after the encounter, or else the evaluator is not responsible to include in this initial report and would then report on these "delayed" records later in a supplemental report and get paid accordingly. By leaving this question open

it is possible for the evaluator to receive the records 29 days after the encounter and then have only one day before the 30 day deadline to address them. This would be untenable if the records were in excess of a small number of pages. Please clarify the deadline question

2. As an Internal Medicine Evaluator I get asked to opine on very complex conditions and to also opine on the industrial nature of these conditions. This often requires extensive research which I include in the report along with the references and links. As it stands now, I get paid per hour of research. Is this not going to be the case in the future??? W th the proposed changes - only the record review is added and it Is measured by the number of pages. I urge you to reconsider and account for the resea rch that we are required to do in these complex cases.

3. Please also amend the present proposal of who is responsible to count the number of pages of medical records - it should be the burden of the insurance c:djustor or council who provides them rather than put the burden on the evaluator.

4. The complexity factor of 1.5 is applied to "Oncology and To>:icology Cases." To qualify for this complexity, one must be a Board-Certified Oncologist or Toxicologist. In the American Board of Internal Medicine which sanctions all the internal medicine 5ubspecialties, there is no Board of Toxicology. This special training is usually done by Emergency Room Physicians and other traumatologists. I fear that as an Internist I may be asked to do a report on these complex cases and I will be responsible to do the necessary research without getting the benefit of the complexity factor that the report deserves. It would be best if you define the scope of the report to qualify the need for the complexity and allow the entrusted evaluator to benefit from such, rather than require qualifications that quite clearly will not be available in the present population of Internal Medicine Evaluators

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Clare Elkin Baum, PHD July 10, 2020

I am a psychologist and have been a QME since 2011. I have reviewed the DWC's proposed fee schedule and find it to be grossly insufficient, especially with regard to reimbursement for psychologists/psychiatrists. As a psychologist, the evaluations that I conduct are highly complex and involve face-to-face interviews that can take anywhere from 2 to occasionally as much as 5 or 6 hours for an initial evaluation, depending on the applicant's psychological history, trauma history, medical history, their degree of

emotional and physical distress, the nature and extent of the claimed injury and the nature and extent of any nonindustrial factors that may be contributing to the psychological condition. An evaluation involves the administration, scoring and interpretation of psychological testing. All of the data obtained during the evaluation and medical records must be considered in forming a diagnosis and opinions regarding medical causation. Unlike other specialties, the number of medical records is not an accurate predictor of the complexity of the case. The proposed fee schedule which involves a flat fee with the proposed 1.5x modifier plus reimbursement based on the number of pages of records could lead to as much as a 70% decrease in reimbursement for QME psychologists and psychiatrists. There has been no increase in the reimbursement rate for QMEs since 2006 and now the DWC is proposing a fee schedule that will result in a considerable decrease in reimbursement. I take pride in providing thorough, thoughtful and constructive reports and I would not be able to continue as a QME under this proposed fee schedule. CSIMS is proposing that the mental health modifier be increased to 3.0X. Anything less would be grossly inadequate**.**

I have also learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several other key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process. DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an automatic annual COLA increase for QMEs, utilizing the DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- The mental health modifier should be increased to 3.0x
- The definition of a missed appointment should be expanded to allow for: the injured worker leaving prior to completing the evaluation, the interpreter not showing up; the interpreter leaving prior to completing the evaluation,QME

discontinuing the evaluation due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)

- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report
- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.
- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.
- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier

Please follow CSIMS recommended changes to the fee schedule. If you go forward with the proposed changes, you will lose QMEs and injured workers will be the ones who suffer.

Adele Gainsley July 10, 2020

I have worked for doctors who do medical-legal evaluations in Workers' Comp for several years, and have more recently been working with a highly experienced and well-regarded Qualified Medical Examiner and Agreed Medical Examiner in Psychiatry practicing in Southern California.

As proposed, this prohibitive fee schedule would mean that the psychiatrist I work for would be unable to produce the kind of reports needed by Workers' Compensation. Without being fairly compensated for the doctor's time on an hourly basis, like other psychiatrists and psychologists, like the lawyers with whom the doctor works, and like other professionals, the doctor would no longer be able to work as either an AME or as a PQME, and I would be out of a job.

The doctor pointed out Labor Code 5307.6 to me. It's stated that doctors should receive "…fees which provide remuneration to physicians performing medical-legal evaluations at a level equivalent to that provided to physicians for reasonably comparable work, and which additionally recognizes the relative complexity of various types of evaluations, the amount of time spent by the physician in direct contact with the patient, and the need to prepare a written report."

This flat fee schedule is impractical, confusing, open to misrepresentation and misinterpretation. Ultimately, it is unworkable. I would understand that, for psychiatrists, instead of a raise, this would be a major decrease in payment, where the doctor fears having to close the office.

I appreciate the opportunity to comment upon these changes and express my concerns for the far-reaching consequences of this proposal.

Michael Tooke, MD, MPH, FRCSC, FAAOS July 10, 2020

I am writing to register my disappointment in the current DWC medical-legal fee schedule proposal. Since 2013, I have done approximately 1500 face to face orthopaedic evaluations including initial evaluations and re-evaluations. I have seen my remuneration for these reports decline steadily for the past 3 years. The decline began around the time when the underground regulations were invoked, without due notification that the ground rules were changing. My QME practice yields about 50% of what it did six to seven years ago, although I spend just as many hours as I did then. I have not quit, simply because I cannot afford to, having stopped doing surgery in 2014 at age 66. Hence, I have worked hard, made less, and cannot have helped but contribute to the record profitability to the insurance industry. It is not lost on me that the DWC has failed to increase the medical-legal fee schedule in synchrony with the medical fee schedule as required under the law. During my tenure as a QME, I have also observed the manner in which the DWC DEU bludgeons and intimidates QME’s, with no regard for our professional status or diligence in the work we do. My personal experiences include dealing with the usual erroneous attorney allegations of late report submission (when the report does not support the attorney’s point of view) and a report audit that required me to retain an attorney.

My experiences have led me to believe that where physicians are concerned, there is no

reason to trust the DWC. I have finally understood that the DWC will side with the insurer over a physician every time. Therefore, it was no surprise to me that the DWC apparently undercut the tacit agreement reached at the stakeholders' meetings between physicians and insurers. The resulting proposal fails to safeguard the role of the QME, which, in the context of an adversarial/litigated workers' compensation system, is a vital element in the equitable treatment of California Injured Workers. The overall attitude of the DWC DEU is epitomized by the fact that I, a person who is very engaged, would not even know there were stakeholder meetings happening if were not for the organization CSIMS. It seems a little peculiar that the DWC would not inform every stakeholder that meetings are scheduled and ongoing. The DWC certainly knows how to contact all QME's when the issue is a threat to exercise its power over a QME, so I know DWC knows where we are and how to contact us. How hard could it have been to send an email to every QME informing us of the process that is underway.

Specifically, the matter of payment for medical record review is completely unsatisfactory under the new proposal. It would appear the DWC has invoked the concept of a 'volume discount.' What logic would result in paying less per page for medical records in excess of 2000 pages eludes me. I have reviewed medical records with 6000 pages and there was nothing about pages 2000 through 6000 that was any easier, or less time consuming than the first 2000 pages.

Furthermore, $3 per page is not enough. Based on 100 pages per hour of review time, the hourly rate is $300, which neither recognizes the expertise that skilled doctors bring to bear, nor the arduousness of the task. A more reasonable rate would be $3.50 per page for every page after the first 100 pages (not 200 pages). Additionally, a page needs to be quantified/defined because many of the current electronic healthcare records (EHR) print out with very small font, and each page is packed top to bottom. The size of paper needs also to be specified, 8 ½" x 11".

Additionally, the records need to be provided by the day of the evaluation, not later. Any records submitted after the day of the evaluation should be dealt with in a supplemental report. I cannot conceive of receiving 2000 pages of records one week before the report due date, and having to perform the review under threat of punishment by the DEU for tardy service of the report.

Provision of surveillance video should be treated the same way as records: submission after the day of evaluation requires a supplemental report.

While there are many other issues my CSIMS representatives are advocating, and with which I agree, I would like to comment on the refusal of DWC to entertain an annual COLA. We need that badly. Sixteen years of neglect and forced subsidization of the insurance industry is enough to make it clear that that QME physicians need some codified ongoing commitment/protection.

Above all we need a DWC that is accountable to all, including doctors that keep the

gears of a very imperfect and frail system moving. I fear that is a vain hope.

Sarvanan Ram, DDS July 10, 2020

The new fee schedule is a step in the positive direction. However, I would recommend increasing the fee for per page reimbursement in a fashion similar to other states. My suggestion would be to reimburse at a higher per page fee rate as record review is a time consuming and laborious process. I suggest:

- After 200 pages, the proposed reimbursement is $4/page up to the next 1,800 pages of records. After initial 2,000 pages reimbursement would be $3/page thereafter

- Supplemental reports reimburse at $650 to include 50 pages of records. From 51-2000 pages reimburse at $4/page in addition to the $650

Edwin H. Peng, MD July 10, 2020

I consider myself to be an organized, detail oriented and efficient physician. I have now been performing psychiatric qualified medical evaluations for just over 3 years. During this time, I have tried to conscientiously write reports that capture the information requested while trying to maintain a reasonable cost of my work. I feel that I have aptly accomplished this. As I have progressed through the learning curve, the information provided in my reports are more succinct and relevant. I would estimate that I now generate comparable reports in 25% less time than I did my first year.

With that being said, the new DWC med-legal fee schedule provides a rate for psychiatrist that is equivalent to 12 hours of work with our current billing schedule. It is unrealistic for the majority of my reports to be accomplished within this time frame. Unlike other specialties, questions are not as easily reconciled by ordering a diagnostic test. In the field of psychiatry, when discrepancies arise, further exploratory questions or a detailed examination of the records is required. To develop an understanding of a person’s mental state, the process is lengthy. I estimate my interviews average approximately 4 hours. I have had interviews which uncovered past physical/sexual abuse, alcoholism/drug addiction, undisclosed health issues and numerous other factors. I do not believe that I would have been able to uncover these issues if I simply accept a person’s explanation even when they do not entirely make sense. However, “cutting corners” is precisely what would happen if I am trying to work faster. Moreover, whether an individual has credibility becomes more evident the longer the interview lasts. Credibility is a key element of the psychiatric interview because we do not have

the same diagnostic tests that other specialties rely on when contradictions arise. Restricting the time that we spend would absolutely hurt our ability to determine the credibility of an individual. Similarly, it takes time to write a report that captures all the elements that influence an individual's psychiatric condition and reconciles any discrepancies. In other words, the breadth and depth which we perform the psychiatric interview is the equivalent of diagnostic lab tests, imaging studies and other such tests which incur additional costs in other specialties. In my experience, 12 hours is not sufficient to accomplish all that is asked for psychiatric reports.

I guess the DWC could expect me to take a different view. That I should not try to fit the amount of work into a reduced number of hours. Instead, I should perform the same quality of work in whatever time is required. This, of course, means that I am accepting a lower hourly compensation for my time. For me, this is not possible. Even with the current pay structure, my hourly compensation is far lower than any of the other work that I perform as a physician. After deducting the various associated costs, the ML-104 rate of $250 is far less. There is a threshold for the value of my time below which continuing would not be sensible. I feel the current pay schedule already borders on this. It would not be logical to continue if the proposed schedule is adopted. I think that this is probably the case for many who perform QME work.

With that being said, adjustments would be needed so the proposal is more palatable. Having worked in various fee for service model, a straight hourly compensation has always been the simplest and most fair. I understand that the move to a flat fee model is partially in response to the fear of uncapped billing. However, the flip side to that is the risk of exploiting psychiatric labor - an actuality with the currently proposed flat rate.

On the surface, it seems a compromise could be reached by reducing the scope of work for the psychiatric QME as this would lower insurers' costs while maintaining a reasonable hourly rate for the QME. However, the quality of the work product would certainly drop with a superficial nod given to relevant issues. The addition of billing code ML206 then becomes particularly onerous as insurers and parties involved could claim that multiple issues should have been addressed more thoroughly in the initial report. I do not see that there is an easy and fair solution in trying to reduce the psychiatrist workload though I am open if something reasonable it proposed.

From my perspective, the only equitable solution is for psychiatric compensation to be increased to justify the hours we would spend producing the same quality of work. The current proposed 1.5x modifier is inadequate. I have seen a 3x modifier to the proposed flat fee and record review rate which I believe to be fairer. Based upon the time I spend for a typical case, a 3x modifier still results in an hourly compensation below that of other fee for service providers. However, it would not result in a reduction in hourly compensation. I also believe that the ML206 code has the potential to be abused and should be eliminated.

As a final comment, I read a remark about the altruistic calling for medical professionals. In my private practice, I have always had individuals who occasionally fall on hard times. I frequently work with them through a reduced or even waived fee. Additionally, I correspond through phone or email which are unbilled activities. This has been more prevalent over the last few months given the current climate. I think that it would be wrong to equate the altruism needed to provide no or low-cost psychiatric treatment to people in hardship with accepting a pay cut to defray the insurers' cost for the purpose of workers' compensation. The two are not comparable.

Wayne Bardwell July 10, 2020

The proposed changes are unacceptable. If enacted, this fee schedule will increase the administrative burden on QMEs, not compensate them fairly, and undoubtedly reduce the already record-low number of QMEs still left in the system.

DWC has intentionally NOT applied the psych multiplier to record review. This makes no sense. Reviewing medical records from a mental health perspective is inherently more time-consuming and complex than reviewing medical records for a non-psych specialist. I urge DWC to increase the multiplier to at least 2.0x **and** apply the psych multiplier to record review fees, not just the flat fee.

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders. Why has DWC ignored this widely supported proposal?

Sue Honor's proposal and the accompanying petition can be found here:https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

Further, the fact that DWC has disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement DWC proposes is far below Sue Honor's recommendation and even less than the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor

reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge DWC to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Brett Freeburg July 10, 2020
President
Med-Legal Xchange

The greatest shortfall in the concept of a flat rate fee schedule is that it belies the simple reality that some cases are far more complex than others, which is the very nature of forensic evaluations. Some Injured Workers are 19 years old with no relevant work or life history, while others are 60 years old with 40 years of work history, a lifetime of stresses and traumas, as well as multiple preexisting conditions both industrial and non-industrial. This concept was correctly acknowledged by the DWC in the 2006 fee schedule when they stated; "The complexity of the evaluation is the dominant factor determining the appropriate level of service…" in the § 9795(b). The primary problem with the 2006 fee schedule is that it has not been updated to adjust for inflation/COLA since 2006.

This series of low-ball, "fee schedules," is best seen as an attempt to wear down the will of the QME community by incrementally giving "more" with each iteration, until they can get enough buy-in from certain segments to implement some version of a "flat" fee schedule, which will adequately compensate enough providers (primarily orthopedic panels which constitute around 54% of all panels, and other specialties who perform primarily ML 102/103 evals) at a higher level than the current ML-102 and ML-103 level reports, but woefully fail to fairly and adequately compensate QMEs, for their time, overhead cost, effort, and expertise on complex cases and in specialties that typically see more time consuming cases. It should be very telling to the DWC that certain specialties would rather have the proposed fee schedule and consider it to be a "raise" while entire other specialties would rather continue without the "raise" and use the 2006 schedule as is, than use anything resembling this proposal.

Are workers' compensation attorneys paid the same amount for a case which settles in six months for $20,000 as for a case that goes on for seven years before the applicant is awarded $1,000,000? Does the treating physician get paid the same amount to evaluate and treat the worker with a sprained wrist as to evaluate and surgically repair a compound fracture of the radius and ulna? Are Workers' Compensation Judges docked

pay every time a hearing is taken off calendar or every time a party fails to appear? Do the employees at the DWC get paid the same amount no matter how many absurd fee schedules they promulgate?…… technically they do, but they are salaried 9-5-ers. They are never up till 2:00 AM reading 1000 pages of records received today for and evaluation tomorrow. Nor do they spend evenings and weekends writing med-legal reports beyond their already full workdays.

Yet, in one major area the salaried employees at the DWC are far better off than the QME community, as their pay increases every year, frequently by more than COLA. From 2018 to 2019, Dr. Raymond Meister, Executive Medical Director Division of Workers' Compensation, saw his base salary increase 4.8%, and in the four years he has held that same position his pay has increased by 18.9% in total (all data in this paragraph was gathered via transparentcalifornia.com). George Parisotto, Administrative Director of the Division of Workers' Compensation/Department of Industrial Relations saw his regular pay increase 9.0% from 2018 to 2019. Winslow West, while working as Industrial Relations Counsel IV, had his regular pay increase 4.3% from 2018 to 2019. Yet the DIR still cannot see the rationale, logic, and necessity in providing for any sort of cost of living increase in what is amounting to be a once-per-generation update to the Med-Legal fee schedule…….. Hypocrisy? You decide.

Many people no doubt will provide their feedback so I will not belabor the points that will be reiterated time and time again in the comment forum. I do want to bring your attention to a few flaws in this new iteration of the proposed Med-legal Fee Schedule.

1) The DWC has acknowledged that the QMEs time is worth something, they just cannot decide how much. They apparently believe the value of the QME's time depends on what the expert is doing. $455 per hour for deposition testimony and prep time (which, while generous, may be even be too high of a rate, despite it coming 16 years after the last fee schedule adjustment). This fee structure would seem to encourage QME's to want to go to deposition, when the mission of the DIR should be to encourage high quality reporting, obviating the need for depositions. However, that same expert's time is only worth $325 per hour (a reasonable hourly rate 14 years after the $250 rate from 2006) if they are watching sub-rosa video. Yet when that same QME is reviewing medical records (at the sometimes accurate but nonetheless somewhat arbitrary standard or 100 pages per hour) for an initial evaluation their time is worth $3 per page ($300 per hour) for pages 401-2000, but only $2 per page ($200 per hour) for pages 2001 - infinity. The value of that same QMEs time magically changes for a follow-up evaluation where pages 201 to 400 are now worth $3 per page along with pages 401-2000. And for a supplemental evaluation page 51 through 2000 become worth $3.

2) Take the example of an ML202, “Follow-up Medical Legal Evaluation”, paying $1316.25 under the proposed fee schedule. The doctor receives 800 pages of records, only 400 of which turn out to be new. The QME first must organize and compare the 800 pages of records to the previously received records to determine which records are the “new” pages compared to records they received 23 months ago. Conservatively a one-hour project. Then the QME still must read the 400 pages of “new” records, reading around 100 pages per hour requires around four hours reviewing the new records if they are not dense. The Internal Medicine QME who spends then spends the minimum 30 minutes (not the 20-minute minimum for a neuromusculoskeletal evaluation) for an “uncomplicated evaluation” (Title 8, Div. 1, Ch. 1, Article 4.5) with the applicant. The QME is at the very least five and on-half hours into this evaluation, they still have not formulated an opinion or written a word of their report, and at this point the QME is being paid $239 per hour. From that point their reimbursement per hour of work continues to fall with every minute they spend formulating their opinions, integrating the data from the new records, and writing/dictating/editing their report. As a fairly conservative total, say the QME has one hour of record sorting time, four hours of record review of the “new” 400 pages of records, 30 minutes of face to face, 30 minutes formulating their opinions on causation and apportionment, and two hours writing/editing their report. The QME has 8 total hours and is earning $164.53 per hour, 66% of the old fee schedule.

3) Take the following two scenarios as examples of ML 201 psych cases:

a. Case A: turns out to be a complex CT with multiple specific injuries. This evaluation entails 15 years of employment history, prior industrial and non-industrial psych injury, and 200 pages of dense records including the applicant’s deposition transcript, psychological and psychiatric treatment records, personnel records, investigative reports, and a psych PQME report from a previous claim. Applicant A is severely depressed, of below-average intelligence, and psychologically naïve. Applicant A is a native English speaker, who is reluctant to participate in the evaluation process, and struggles to fully answer questions, maintain focus, and needs to be redirected frequently throughout the evaluation, the interview for which requires 8 hours to complete. The applicant and QME come back the next day to complete testing which requires a further 4 hours (which is only billed under the appropriate CPT codes). The 200 pages of records are exceedingly dense, consisting of highly relevant information, the applicant’s deposition, psych treatment records, and a psych PQME from a previous injury, and they take 5 hours read. The report is lengthy, complex and takes 16 hours to complete.

b. Case B: turns out to be simple adjustment disorder from a recent specific injury which has resolved without mental health treatment. Records consist of a doctors first report, A referral for psych assessment, and 2000 pages of duplicative records from three different Kaiser facilities, most of which are irrelevant and consist of discharge instructions, patient information sheets, records from the prenatal care and births of three children, every sniffle, stubbed toe, and minor laceration the applicant had for the past 15+ years. Applicant B is highly intelligent, though not a native English speaker and is not fluent, so an interpreter is present at the evaluation to help with some of the medical terminology and other unfamiliar terms. Applicant B is psychologically sophisticated with good insight, is comfortable with the evaluation process and participates fully, allowing the interview to be completed in a shorter than average 3 hours plus one hour for testing. The 200 pages of records, though voluminous, are duplicative and largely irrelevant, taking only 5 hours to read The report is short and straightforward with 100% industrial causation, no permanent disability/apportionment, and only take 8 hours to formulate, write, and edit.

Case A requires 5 hours more time face-to-face due to the long and complex injury history, past history, and current condition of applicant A. Applicant B, despite being “translated,” is a better communicator and is able to answer questions succinctly and stay on point for the duration of the interview, unlike applicant A. Case A requires about the same, if not more time, to read and summarize the records as they are all relevant, dense, and are not duplicative. Case A will require more time to integrate data and formulate opinions. Case A requires more time to write the history and current condition sections of the report due to the longer history and previous injuries involved. Case A requires a complex Rolda analysis regarding causation not applicable to Case B. Case A requires a lengthy discussion of permanent disability and a complex apportionment analysis not applicable to Case B. In addition, the discussions of causation and apportionment in case A have to be substantiated and supported in a manner that meets the “substantial medical evidence” standard while accounting for all the pertinent facts and data which are not present in Case B. Under the new proposed fee schedule the QME in Case A (8 hours face-to-face, 5 hours reading records, 16 hours report writing) will be paid $3,022.50, or $104 per hour. Meanwhile, the QME on case B (3 hours face-to-face, 5 hours sorting/reading records, 8 hours report writing, with a x1.1 modifier for the interpreter) will make $8,624 for 16 hours of work, or $539 per hour. If it is the goal of the DWC to discourage QMEs from spending the time required to write high quality reports on the complex cases which need it the most…..they have succeeded with this proposal.

Simply updating the ML 102 and ML 103 flat rates, and the base RV rate to account for COLA since 2006 would be far better and simpler solution than this proposal. However, I would encourage an abandonment of the flat fee model altogether. This will motivate high quality experts to become or remain QMEs and for them to write high quality reports, resulting in fewer supplementals, depositions, and a quicker resolution to cases. The DWC Medical Unit can focus their energies on QME training, continuing education, and monitoring for report quality, a task they have been delegated but have failed to perform for years. QME or AME reports a party truly believes do not meet the substantial medical evidence standard, (not just opinions that one side does not like) can be objected to by a party and the issue can be resolved using the existing § 10786 Determination of Medical-Legal Expense Dispute mechanism. The feedback to underperforming experts provided by this process will encourage the “good” experts to improve and the “bad” experts to drop out, or the DWC can perform their oversight duties and weed out QMEs for repeated failure to produce adequate reports as determined by the WCAB. In the same way, utilizing the existing § 10786 the employer/defense counsel/claims adjuster can object to an experts billing if they believe it to out of line, and the WCAB can determine whether the provider’s billing was reasonable given the time spent signed under penalty of perjury, case complexity, medical/psychological issues, and records involved in the case.

Cover letters and records should be required to be served on the QME no less than 15 days prior to the scheduled date of evaluation. If cover letters and records are not received at the address listed by the evaluator on the QME 110 form 10 days prior to the evaluation, the evaluator can, at their discretion, unilaterally reschedule the evaluation date between 30 and 60 days out to allow time for the parties to provide records timely, which allows the evaluator to review them prior to the forensic evaluation. How can any evaluator be expected to conduct a thorough forensic interview of an applicant if they have no idea what the case is about and are not able to ask questions about pertinent details documented in the records which an applicant may not think is important, remember, intentionally fail to disclose, etc.?

Parties should be required to send chronologized and de-duplicated records. If one of the goals of the new fee schedule it to cut costs, STOP using the QME offices as file clerks. Complex cases and cases where the parties send thousands, or 10,000+ pages of unorganized records will, and should, cost significantly more. The insurance companies/employers can save themselves a great deal of money by sending de-duplicated and organized records. Rather than pay the QME at RV 5, they can pay someone who does not have a doctoral degree much less to remove duplicates, fax cover sheets, discharge instructions, and to put the records in chronological order. It is a tedious and time consuming task, which is the reason attorney offices and claims adjusters do not do it themselves. I would hazard a guess that insurers and employers could save many millions per year by paying their own staff to do this work rather than paying RV-5 to QMEs.

The following is my proposal for a fair, simple, and straightforward Medical-Legal Fee Schedule.

1) The RV base rate should be increased to $65 to account for inflation since the last ML Fee Schedule.

2) RV-5 adjusts each year to account for COLA.

3) ML 200, Missed/cancelled Appointments. Evaluations which are missed, cancelled within 10 days, when either the injured worker or interpreter fails to show, shows up sick or under the influence, is more than 30 minutes late, or cannot stay for the duration of the appointment; are billable at two hours at the RV-5 rate, and four hours at the RV-5 rate for Psychology and Psychiatry.

4) ML 201, Medical-Legal Record Review. Under this code the physician shall be reimbursed at the RV 5 rate for all time spent counting pages, organizing records, de-duplicating records, reading records, reviewing the physician's own prior reporting on the case if applicable, or reviewing sub-rosa. The total number of pages of records received, and time spent reading/reviewing the records shall be attested to in the billing section of the report and signed under penalty of perjury. The physician may also bill under this code at the RV-5 rate for any time spent reading and/or summarizing records received any time prior to a missed appointment as defined under ML 200, or prior to receipt of written notice of cancellation. If a written record review has already been created or partially created at the time of cancellation, the review shall be included with the invoice for this service. If the cancelled evaluation goes forward within 60 days of the original date of evaluation, the physician may not bill a second time for the parts of the records which had been previously billed for.

5 ML 202, Comprehensive Med-Legal Evaluation (Initial and follow-up). Under this code the physician shall be reimbursed at the RV 5 rate for all time spent face-to-face, performing medical research, writing, and editing the report, signed under penalty of perjury. At minimum, the defendant's cover letter (as required by Title 8, Div. 1, Ch. 1, Article 3, Sec. 35) and any records for a comprehensive Med-Legal Evaluation are required to be served on the QME no less than 15 days prior to the scheduled date of evaluation. If cover letters and records are not received at the address listed by the evaluator on the QME 110 form, at least 10 days prior to the evaluation, the evaluator can, at their discretion, unilaterally reschedule the evaluation date between 30 and 60 days out to allow time for the parties to provide records timely which the evaluator can review prior to the forensic interview.

6) ML 203, Fees for Supplemental Medical-Legal Evaluations. The physician shall be reimbursed at the RV 5 rate for all time spent performing medical research, writing, and editing the report, signed under penalty of perjury. The review of any records sent in relation to the supplemental report are billed separately under the ML 201 code. In the event that additional records are received at a date after a written supplemental request or additional records unaccompanied by a supplemental request the physician may choose to incorporate the additional records into a single evaluation with the due date being determined by the last records set received, or they may issue two separate reports. The fee includes services for writing a report after receiving a written request for a supplemental report from a party to the action, or for writing a supplemental report following receipt of additional records less 10 business days prior to a comprehensive medical-legal evaluation. At the QMEs discretion they may review and include the late records (records received less than 10 business days before an evaluation) in the initial or follow-up Comprehensive Med-Legal report, or they may issue a supplemental report.

7) ML 204, Fees for Medical-Legal Testimony. The physician shall be reimbursed at the rate of RV 5, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. The physician shall be entitled to fees for all itemized reasonable and necessary time spent related to the testimony, including reasonable preparation and travel time. The physician shall be paid a minimum of two hours (one hour of reserved deposition time and one hour minimum of prep time) for a deposition prior to the commencement of the deposition. Upon the conclusion of the deposition the physician shall provide an itemized statement of any preparation time beyond one hour and any additional deposition time, if any. The balance of the invoice is due within 5 business days. If a deposition is canceled fewer than six (6) business days before the scheduled deposition date, the physician shall be paid the minimum two-hour fee for the scheduled deposition.

8) The modifying circumstances shall be identified by the addition of the appropriate modifier code, which is reported by a two-digit number placed after the usual procedure number separated by a hyphen. The modifiers available are the following:

a. -92 Performed by a primary treating physician. This modifier is added solely for identification purposes, and does not change the normal value of the service.

b. -93 Interpreter needed at time of examination. This modifier is added solely for identification purposes, and does not change the normal value of

the service. No modifier is needed as reimbursement is based on time spent face-to-face.

c. -94 Evaluation or med-legal testimony performed by an Agreed Medical Evaluator. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.35.

d. -95 Evaluation performed by a panel selected Qualified Medical Evaluator. This modifier is added solely for identification purposes, and does not change the normal value of any procedure.

e. -96 Evaluation performed by a Psychiatrist or Psychologist. This modifier is added solely for identification purposes, and does not change the normal value of the service.

f. -97 Evaluation performed by a physician who is board certified in Toxicology. This modifier is added solely for identification purposes, and does not change the normal value of the service.

g. -98 Evaluation performed by a physician who is board certified in Medical Oncology. This modifier is added solely for identification purposes, and does not change the normal value of the service.

Lisa Wolf, Psy.D. July 10, 2020
Psychologist

As you are no doubt aware, Workers' Compensation was initially established as a "grand bargain" between employers and labor. Injured workers gave up their right to sue employers in civil court for workplace injuries, making Workers' Compensation the "exclusive remedy" for such injuries. In exchange for this, injured workers received statutory benefits in a no-fault system.

In the century since that grand bargain was reached, the State of California has endeavored, by a thousand cuts, to reduce those statutory benefits and impose increasingly stringent standards of proof in this "no-fault" system. I speak from the perspective of a Qualified Medical Evaluator in Psychology who has been involved in the California Workers' Compensation system since 1989.

When I began in this field, the standard of proof for the causation of psychological injuries in WC in CA was 1%, as it remains, today, in orthopedics, internal medicine and every other discipline. Over time, the psychological injury threshold was raised to 10% and, now, 51%. To further limit employees' access to their guaranteed benefits,

exclusions were added for injuries sustained during the first six months of employment, for those filed after termination and for those resulting from lawful, good-faith, non-discriminatory personnel actions. The applicant's subjective perception of work-related stress was replaced with the "Actual Events of Employment" standard. Most recently, with the passage and implementation of SB 863, psychological injuries that developed as a result of orthopedic injuries were deemed non-compensable with regard to permanent disability.

Simultaneous with these restrictions on compensability, the State has disincentivized doctors from entering the WC arena by failing to match reimbursement rates for medical-legal reports to the cost of living. Reimbursement for Qualified Medical Evaluations has been unchanged since 2006. For comparison, the cost of living in the U.S. increased by over 50% between 1999 and 2020, according to the Federal Bureau of Labor Statistics. The cost of living in CA has increased as well, but more steeply.

The State's failure to adjust the MLFS is in direct violation of California Labor Code §5307.6(a) which states that, "The administrative director shall adopt and revise a fee schedule for medical-legal expenses...at the same time he or she adopts and revises the medical fee schedule." While the OMFS has undergone multiple fee increases during the past fourteen years, there have been no such adjustments to the MLFS.

WHY?

Because the Insurance Industry has promoted the false narrative that they are being crushed by the weight of WC medical and medical-legal costs. IN FACT, the insurance industry has amassed unprecedented profits since the implementation of SB 863 in 2013. During that same period, fees paid to doctors for medical-legal evaluations have decreased by 10%, from 4.9B in 2013 to 4.4B in 2018.

The result has been an exodus of doctors from the WC system in CA. Between 2008 and 2018, the population of CA increased by approximately 8%, from roughly 36.6M to 39.5M, while the number of requests for Qualified Medical Evaluations increased by 114%, from 70,000 per year in 2008 to 150,000 per year in 2018. Because of the State's failure to increase compensation to doctors, during that same interim, the number of QMEs in CA has decreased by 40%, from 3500 to 2100. As a result, **we have fewer than half as many QMEs attempting to meet twice as much demand, while being paid half as much.** The only reasonable response to the current situation: too many injured workers and too few doctors willing to perform the Qualified Medical Evaluations guaranteed by the "grand bargain" is to maintain the current method of reimbursement while Increasing hourly rates for doctors. Ironically, **the most recent Fee Schedule proposed by the DWC actually reduces reimbursement for most psychological evaluations.** To make matters worse, the DWC has proposed an entirely new, completely unnecessary, poorly designed and utterly confusing set of

billing codes to which doctors will be required to adhere. They are reinventing the wheel when all that is needed are routine upgrades to the tires and tubes.

The new fee schedule, for example, proposes that doctors be paid per page of medical records reviewed rather than per hour of time actually spent examining a claimant and producing a legally-useful report. First, what constitutes a "page" is not delineated. One page could be a copy of 3x5 prescription pad or an 11x17 legal document, a typed summary from a 15-minute exam to remove stitches or a partially-legible, handwritten clinical note from a one-hour-long psychotherapy session.

Second, there is no specification as to who counts the pages or who verifies that count. If page counting is left to the doctor, an additional hour could easily be spent, especially when records are sent digitally, in individual emails or attachments. My most recent case had 93 such attachments. Is this really how the DWC wants doctors spending their time?

Third, a page of medical records is not a fair or reasonable metric of the complexity of an examination. It does not account for the time spent obtaining a history from an injured worker. By State law, psychological evaluations are required to address a claimant's early history, educational history, occupational history, medical history, psychological history, drug and alcohol use history, legal history, military history, marital history, etc. As you can imagine, a claimant who has held 20 jobs in the past ten years, been incarcerated on multiple occasions, sustained repeated injuries in car and other accidents, been married more than once and/or raised a half-dozen children with medical, psychological, drug, alcohol and/or legal problems of their own cannot tell their entire life story in fewer than 3 hours. Transforming that vast amount of information into a coherent, chronological narrative, and integrating that data with the chronology of their work-related injury is no small task. There is no way in which this level of complexity is captured by the size of the claimant's medical file.

Ironically, it is the type of complications noted above that work in the defendant's favor. The Devil is in the Details. If doctors are compelled, due to time and financial constraints, to perform more cursory exams, they will focus primarily on the work-related injury and associated symptoms. There will not be sufficient time to explore the myriad non-industrial factors which bear on issues of causation and apportionment. As a result, **those exams will, necessarily, favor applicants.**

I'm certain that my colleagues will address, in detail, the many flaws in the proposed fee schedule. My goal was to place the proposed schedule into historical and economic context. I assure you that no doctor who values his or her personal integrity or professional license or who cares at all about the quality of services being provided to injured workers will continue performing QME exams for less than they are being paid, now. More importantly, the heaviest burden will fall on those who are injured while

providing goods and services to the rest of us, for they have no alternative to the "exclusive remedy" of Workers' Compensation.

Sarbjit Dhesi, DC, QME July 10, 2020

I am a QME since 2000. I am a member of CSIMS and CCA.

I have performed quite a few QMEs over the years, and since 2006 there were no updates to the fee schedule while the cost of living and other factors increased dramatically over the years. Per the audit report, this became very apparent not only affecting QMEs staying on as providers but also hurting access for injured workers.

To address this, I appreciate the effort being put forth by the parties to address these shortcomings that are long overdue. I have also appreciated allowing stakeholders to be allowed to submit thoughts, proposals, and ideas as we all move forward to address the deficits.

I had the chance to review the proposed fee schedule, and I do have some comments that I would like to submit.

1. I understand the parties on all sides [the providers and the insurance carriers and DWC] want to make the process of billing for QME's more transparent and straightforward. The flat rate process is a good start. For quite a few providers that perform more extraordinary complex exams, the flat rate fee schedule will not result in a significant increase compared to 2006 rates even with the page count add on. This is something to consider as we already have a low number of providers who are requested to perform these exams more regularly. These are not necessary AMEs, and the multiplier will not apply to them.

2. The other issue that concerns me is regarding the page count set up. A better definition of what counts as a page needs to be made, which should be 8.5 by 11 standard with a standard 11 or 12 point font.

3. The reimbursement standard on the per-page count does not make sense to lower the $ amount after 2000 pages. Flat rate for all the pages makes more sense as the provider still has to review every page, and pages after 2000 take the same amount of time is pages under 2000. The dollar amount per page is also less than Nevada and maybe a bit on the low side.

4. In respect to the definition of reevaluations, the current standard of nine months or even pushing up to 12 months makes more sense. Having the standard at 24 months for definition reevaluation does not make sense. There are significant changes that can

take place in an individual, including changes in exam findings, changes in medication usage, medical treatments, and other confounding factors that need to be considered during examination. This cannot be adequately addressed in a reevaluation standard at 24 months, a 12-month reevaluation definition is more ideal.

5. As someone who does evaluations regularly, I try to have my reports typed or dictated within the first 48 hours after seeing the injured worker. Having medical records available prior to the evaluation is not only ideal, but it allows better assessment of the injured worker and allows me as a QME to better address some of the disputes in the case by examining disputed areas better or asking better questions during the history portion of the evaluation. If medical records are received too close to the examination or after the evaluation there may not be enough time to review and prep for the evaluation and exam. Thus this is hurting the timeliness of addressing all the issues for the injured workers' case. Having the medical records received before the evaluation is necessary, even if 7-10 days prior. If those records are received after the evaluation, a supplement report needs to be allowed to address the records and change opinions regarding the injured worker, especially for us doctors who would dictate or type reports within a day or two of seeing the injured worker.

6. To avoid future issues similar to what we have today regarding the lack of increase of fees corresponding to the cost of living, the DWC and the parties need to consider an automatic annual cost-of-living adjustment. This is similar to the official medical fee schedule changes that took place with the conversion using the Medicare fee schedule RVUs. This is not a new concept, and this would avoid the DWC and the parties being put in the situation in the future. The amount of time and effort on the parties have had to take for these proposals to go back and forth, and the significant loss of QME's in California, as all documented by the audit report, could be avoided going forward by establishing good standard rates that are transparent moving forward and automatically updated on a yearly basis. The efficiency in the cost-effectiveness of the DWC, and not having to address this with such significant change moving forward, is worth the effort to look into COLA.

Michael D. Ciepiela, M.D. July 10, 2020

I appreciate the consideration to increase our compensation. Those of us who give an honest, objective opinion need to feel our contributions are valued.

Alan Berkowitz July 10, 2020

I believe that the no show fee should be raised to that of an initial evaluation. We frequently travel and the missed appointment leaves a 2 hour gap on most occasions. I suggest a fee of $1200-1500. Thanks for your consideration.

Michael Post, MD July 10, 2020
Chief Medical Officer, RehabOne Medical Group, Inc.
Past President, CSIMS
Past President, CSPMR
Qualified Medical Examiner

I am writing to express my grave concerns about the DWC's proposed revision to the Medical Legal Fee Schedule (MLFS). I had the privilege of attending the last two stakeholder meetings and was extremely surprised when, after several days of thoughtful discussions and negotiations, the administration disregarded a number of those good faith agreements in lieu of this alternative proposal.

I have the unique perspective to have been intimately involved with the last revision of the MLFS, which occurred during turbulent times with the introduction of a new Permanent Disability Rating Schedule schema based on the AMA Guides, as well as major reforms in the entire California Workers' Compensation System. I am well aware of the concept of unintended consequences, and we are now faced with the fallout of those changes, which were highlighted in the recent public audit.

From a historical perspective, it is not surprising that there has been a steady decline in the number of QMEs. For starters, despite the regulatory requirements that the DWC adjust the MLFS every time that the Official Medical Legal Fee Schedule (OMFS) is updated, there has been no increase in the MLFS since 2006 despite the obvious increase in the cost of operating a medical practice. This is a key issue, as it is incomprehensible that any other industry would tolerate this utter disregard for the value of services that medical legal evaluators provide. Additionally, legislative changes mandated by SB 899 and SB 863 have resulted in case law that have greatly increased the complexity involved in providing medical legal reports that satisfy the legal requirements of substantial medical evidence. Furthermore, restrictions imposed by the implementation of Medical Provider Networks has markedly reduced the number of medical providers treating injured workers, which in turn has impacted the number of QMEs that understand the complexities of the system. Lastly, the recent underground regulations with unwarranted disciplinary action imposed by the DWC had a major impact on the current QME crisis.

To my understanding, the underlying impetus behind the MLFS revision was a commitment by the stakeholders to:

- Increase the dwindling pool of QMEs
- Reduce friction points between QMEs and payors
- Provide some level of cost predictability to payors
- Incentivize quality medical legal reports that facilitate case settlement

The California Society of Industrial Medicine & Surgery (CSIMS) initially proposed an hourly fee schedule that considered face-to-face time, report preparation, and converted the number of standardized pages for medical record review to an hourly reimbursement. This proposal was unacceptable to the payors since they wanted a higher level of predictability. They countered with a flat-fee proposal, which ultimately provided the framework utilized at the stakeholders meeting.

From my perspective, the stakeholder negotiations were enlightening as all parties had the opportunity to be heard and present their concerns and representative stipulations. As a result of the "give and take," we ultimately reached a compromise agreement, which was clearly outlined for the DWC representatives. One can only surmise that if the stakeholders reached consensus, that that proposal would be the one presented for public comment. It is inconceivable why the DWC, a reportedly independent and neutral entity, would alter or amend any such agreement.

CSIMS and others have outlined the disparities between the stakeholder agreement and the current proposal, so I will not belabor those points. In order to avert the catastrophic effects that the proposed MLFS will have on the system, I respectfully request that the DWC honor the terms and the spirit of the stakeholder agreement and consider CSIMS's position with respect to specialty modifiers, as well as adding a cost of living adjustment that is included in all the other fee schedules promulgated by the division.

Barry Weiner DPM July 10, 2020

After doing evals for the past 39 years, it is nice to get a meaningful raise. The new schedule is not perfect for all specialties, however for Podiatry and other orthopedic specialties it is a great help and relief. I hope it goes into effect on January 1, 2021 as predicted.

Craig Joseph, MD July 10, 2020

ONE. The California DWC proposal, for which public comments are accepted until 5:00 PM, Friday, July 10,2020v (today),is best described as follows: deficient in providing fair compensation for very complex reports; deficient for having any concern for injured workers in very complex cases; deficient in abiding by agreements reached at stakeholder meetings; deficient in being in compliance with state mandated legislation/rules/regulation/regulations regarding medical legal reimbursement ;and appears to be deficient in compliance with the Bagley-Keene Act(this will require interpretation by lawyers).

TWO. The DWC speaks with a forked tongue. On the one hand it claims to be concerned with the quality of report writing, but on the other hand it ignores the judicial branch of the workers comp system which demands substantial evidence regarding medical conclusions. Very complex reports require an in-depth critical analysis.

THREE. Encumbrances and restrictions on bills for time shall interfere with the doctors providing an in-depth critical analysis regarding very complex reports. As an internist I have had many reports that have required more than fifty hours to prepare. Furthermore,I have prepared some reports that required more than seventy hours. Placing a dollar amount on record reviews is analogous to stating that a one-sized shoe shall fit all-sized feet. Indeed, your stating that the value of record reviews below 2001 pages has a greater intellectual value than for record reviews greater than 2000 pages, is alien to rational thinking. Records can be handwritten or typed or a hybrid of the two. It’s not the quantity of records that determines the time for reviewing records— it’s the information enclosed .Some records are of critical importance, whereas others are worthless.

FOUR. This is how I do my record reviews. For example, an applicant files a continuous trauma claim for 20 years of orthopedic injuries.The applicant claims he took anti inflammatory/nsaids for almost every day during those 20 years to treat his orthopedic injuries. I chronologically sequence the data on consumption of nsaids to determine if nsaids contributed to any derivative injury.

FIVE. The discussions often require more report preparation time than the record time.I have been sent ,on rare occasions, from 10,000 to 16,000 pages of records— do you think intellectual application becomes abridged with the reviewing of boxes of records— people who live in glass houses should not throw stones

SIX. How did we arrive at this juncture? The funding for the DWC is acquired from special assessments on the payors. To correct the inequity of influence at the DWC, other stakeholders, including doctors ,should be contributing to the funding of the DWC.SEVEN. The purpose of my email is to provide support to those of us that need time billing to remain an option .If you would like further communication with me, please feel free to contact me.

Angela West, PhD, QME July 10, 2010

I have reviewed the text of the Title 8: Industrial Regulations, Division 1, Chapter 4.5, Subchapter 1, Article 5.6 Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations with proposed changes being considered now, July of 2020. As a psychology QME with about two years of QME experience, this is not a raise for psychiatric and psychological QMEs. At a stretch, these changes would cause a simple and straightforward mental health case to barely pay the same as the current rate, and for the majority, for the more complex cases, these changes reflect an actual pay cut for psychology and psychiatry. Psychological/Psychiatric QMEs take extensive histories during evaluation interviews that are necessarily long because of common factors like: history of multiple past industrial injuries, multiple personnel actions, multiple injuries included in the same case, complex personal histories, past personal and family psychiatric histories, non-industrial medical and psych conditions, and stressors both industrial and non-industrial, that must be sorted out to methodically determine the weight of each causative factor. Three and three and a half hour interviews are not uncommon at all for initial evaluations with several of these factors that need to be explored and weighted. After the interview, dictation or typing, conceptualizing, formulating causation, and editing for a psychiatric or psychological QME evaluation takes many more hours. I can see how the proposed changes may be a raise for some medical specialties where these long applicant histories are not needed to determine a physical causation threshold of 1%, however, it can often be far more time consuming for a psychiatric or psychological QME to determine whether the cause of a possible mental health injury has reached a threshold of 50%. Then, one must break out whether personnel factors were a substantial cause, and whether a Rolda analysis applies. For each opinion the QME psychologist or psychiatrist must have sufficient justification for the findings and the reasoning for the findings must be explained in the report. For the majority of psyche and stress QME evaluations this is simply not a quick assignment. For all of these reasons the proposed 1.5 modifier for psych is not adequate. I do not agree with a flat rate for psyche QMEs and I feel that psychological QME evaluations, because of their length and complexity, should be broken out and calculated differently from other medical specialties. If a flat rate is applied, the modifier should be 2.5 or 3, depending on how the records a treated.

Regarding records: When I received compressed depositions that have four pages fit onto one 8x11.5 page, these take me more time to review because I have to enlarge and expand the page just to read the tiny lettering. I assert that a compressed deposition page equals four to five pages, not one page and if possible, I kindly request that compressed depositions be disallowed because they create more work. No more four-pages on one page with tiny lettering please. By the same token, please disallow legal size pages unless these are reimbursed at a double rate. Like depositions, legal

size pages and double-sided pages create more work and take more time to organize and review. All pages should be one sided 8x11.5; exceptions should be compensated at a double rate.

Also pertaining to records, I am baffled by the idea that the record review rate is proposed to decrease after page 1,800. In my experience, the cases with more than 2,000 pages of records are more complex and take more time understand, decipher, and conceptualize. It does not get easier or faster to review these records after page 1,800. Asking me to continue to review with the same dedication and quality at a lower rate after page 1,800 is insulting and unacceptable. All pages reviewed should be reimbursed at $3.25 per page.

Please also reconsider timelines. In order to ask the most helpful and appropriate questions during the interview, I try very hard to review all of the records submitted before I meet with the applicant. If I receive records the night before the interview, or after the interview, then I have no chance to read them in advance and ask the applicant relevant questions about factors that stand out from the record review. If you want high quality reports, records are needed two weeks before the interview. This gives a professional time to work on the often-lengthy record review with adequate preparation time for the evaluation. Also, it is unreasonable to ask me to incorporate newly arriving records after I have already seen the applicant. Records that arrive after the applicant interview should be accompanied with a request for a supplemental report.

Whatever formula is decided upon, please make a plan for cost of living increases going forward to spare all of us from having to come back to the table as real inflation impacts the value of every dollar. If this is not already tied to your budget, then please join me in reaching out to our state legislators to assure that you have an adequate budget to meet the legal obligations to pay QME evaluators for the services we provide with routine cost of living increases. Underpayment will lead to lower quality reports, and more supplementals and depositions to drill down on questions that could have been answered in advance in a high-quality report.

Please keep in mind that if the intention of these proposed changes is actually to provide a raise for all QMEs for the first time in a decade, then barely doing enough for psychologists and psychiatrists is not sufficient; the proposal should actually represent a raise for every discipline and specialty. What is proposed here for the psyche QME at the moment smacks more of “How much free work can we get you to do while claiming this is a raise?” If that is not your intention, then I ask you to please go back to the drawing board for psych, and really listen to all of your stakeholders.

Anonymous July 10, 2020

Over the years, the DWC has gotten away with not providing for any COLA increase. We see that all across the nation and in California other professionals have received a COLA increase. That means that the DWC has been effectively cutting reimbursement to QMEs over the years.

We all know that the DWC is not a neutral regulator. They have been in the pockets of the insurance companies for years. When the DWC did the underground regulations to go after QMEs, one may argue that it was because of billing issues. However, given the DWC, used underground rules and prevented QMEs from getting hearings, no one really knows what the case is. We saw that the DWC purposely manipulated the regulations to make it appear that there was fraud occurring. Even the bill review determined that QME reports were being billed correctly in opposition to the DWC. What happened? The DWC lost in district court. All of a sudden, the person spearheading the harm to QMEs, who said they were the judge, jury, and executioner, lost.

What does the DWC do? Well, of course they come up with a retaliatory schedule. It became obvious they hated ML104? Why hate ML 104? Well that is because these are the patients most injured at work. They are the patients claiming years of harassment. They are the first responders claiming 20 years of PTSD. They are psychiatric patient on the verge of suicide. They are the patient on chronic opioids who lost their homes, marriages, and their sources of income. What better way to harm these patients than by going after the QME evaluators?

The DWC proposed another schedule which was worse than the Nevada schedule. Again, it showed that the DWC was going after these complicated patients by trying to target ML 104. The schedule was so poor that it was universally condemned by QMEs as a harm to patients and the ability to provide substantial medical evidence. There was an audit of the DWC that showed that QMEs needed a raise. However, during the pandemic the proposed the telehealth schedule which again showed that they were trying to get rid of ML 104. This current schedule shows again, another attempt to get rid of ML 104.

As mentioned before, we know that the DWC is biased towards insurance companies. It was eastly seen because the schedule before the telehealth schedule was found to have been proposed by an insurance company.

We know that this schedule is an insurance company schedule because what they did was set up a fake stakeholder meeting. The meeting was set up with the refusal to support any hourly schedule and consider any complexity factors. So, the DWC was already forcing a schedule that is biased against complicated patients and the evaluator that did it. The stakeholders decided to compromise based on the flawed schedule and came up with a best terrible schedule possible. It was based on the insurance companies only considering the supply and demand for evaluators and did not consider

patient and how patients with serious injuries will require more complicated evaluations that will cost more money. They even had a sham mental health stakeholder meeting that was for only 20 minutes. Basically, the argument was that mental health practitioners were dime a dozen and could be paid low. There was no consideration of the horrific experiences complicated patients had and the need to be able to provide more complicated evaluations that can take multiple days. There was outrage by many at how terrible the stakeholder schedule was. However, the DWC decided that schedule was not insurance company oriented enough, even though the insurance companies agreed with different concessions. So now the DWC has proposed an even friendlier schedule to the insurance companies with even greater flaws.

What we need is to have the DWC be stripped of the power to propose new schedules. We need to know who every person in the industry the DWC has talked to leading up to the stakeholder meeting and since the stakeholder meeting and what was discussed. We need to know how what sorts of promises or threats are coming from the insurance industry that are leading up to these poor decisions. What would be helpful is to have another audit of the DWC done and find out why the DWC has not chosen to implement the recommendations of the last auditory and what needs to change at the DWC in terms of personnel to get the DWC to be neutral.

We have gotten this far, and we have not been told why we need a new schedule. Have QME reports, as a whole risen in cost? No. Has demand for QME reports gone way up? Yes. Has the DWC purging QMEs though underground regulations caused irreparable damage to the number of QMEs? Yes. That is because there was an acceleration in the decline of QMEs. All the DWC has to do is allow QMEs to get 325 dollars and hour on the ML104 schedule, stop underground enforcement, increase the rates for ML 102 and ML 103 evaluations, have compensation for failed appointments, and increase the deposition rate. Now the system is better and the current system would be much better.

Someone commented an ortho exam can take 20 minutes and the whole evaluation can be 2 hours. Therefore, some people, under the current proposed system, can make 1000 dollars an hour for their simple exams. Again, the healthiest people will have evaluators making the most money.

Some of the most complicated exams can take days. That may include many hours of interview, record review, research, thoughtful consideration and report writing. Those evaluators can even possibly get less than a 100 dollars an hour under the proposed schedule.

If the DWC get a new audit, it will be helpful to find out why they want evaluators with the easiest work to make the most and evaluators with the most difficult evaluations to make the least? The auditor can ask why the DWC is therefore causing the entire system to shift toward making shoddy reports.

The final thing a new auditor can ask is why the DWC is proposing a system what will encourage the most complicated patients to be heard the least. They obviously have long and complicated histories, multiple body parts, and multiple injuries. However, the DWC is not interested in hearing their stories. They are not interested in hearing about their pain, their loss of home and income. They are not interested in hearing about their thoughts of suicide. They are not interested in hearing about how the insurance companies arbitrarily deny their claims or medications. They are not interested in how they have been sexually harassed at work for years. In fact, so many women have extensive physical and mental health complaints and cutting off their ability to be heard is discrimination based on sex. The DWC is not interested in listening to a firefighter recalling many incidents in his or her that have contributed to them drinking alcohol, having extensive physical injuries, and thoughts of death.

You can also tell the DWC is not interested in the complicated patients because very few, if any, patients know what the DWC has been doing and the ramifications of their actions. Do you see patient comments on this forum? Has the DWC sent a letter to the patients telling them about this proposal, to discuss it with their treaters or evaluators, and to comment? No. Basically, they will find out the hard way that after years of having difficulty getting heard, the DWC had destroyed their last chance of getting heard.

All the DWC is interested in is trying to destroy the ability for complicated patients to be evaluated and help their friends in the insurance industry.

G. Charles Roland, MD July 9, 2020

Thanks for all of your comments regarding this work comp system. Some of My thoughts as an orthopedic surgeon are as follows as to what should be approved/done. The care of the injured worker is at stake. I know as an orthopedic surgeon, I will not be able to continue working in this system if the injured worker/patient is not treated fairly:

1) the Deposition reimbursement should be introduced at $455 per hour, billed at the minimum of two hours for the Deposition appointment (one hour for records review and one hour for fate-to-face meeting with the parties).

2) if the Deposition is canceled 8 business days prior to the scheduled appointment, there is a $455 reimbursement fee for a non-timely cancelation.

3) the sub rosa videos must be provided to the QME doctor prior to the patient’s evaluation. The sub rosa video is an additional cost $325 per hour for the physician to review.

4) there is a proposed $325 per hour reimbursement rate, instead of the $250 that is billed now for all ML104 and ML106.

5) all the medical records and Cover Letters must be provided 3 weeks prior to the patient's evaluation. Otherwise, the medical records will be included in the newly-generated Supplemental report.

6) at the time the appointment is scheduled, the parties are requested to list the total number of medical records they are sending to the QME physician for his review. This ensures there is no discrepancy during the reimbursement process by the insurance carrier.

7) the Complexity factors should remain in place, as the report will take much longer to complete for a patient with multiple injuries for multiple body parts at multiple prior employers.

8) The Supplemental reports should continue being reimbursed at the hourly rate, as it serves as a direct response of the QME physician to the questions posed by the parties in the Cover Letter.

The supplemental report also is generated when new medical records are sent for the physician to review. In all cases the QME physician dedicates his time to address the questions posed by the parties and or to review the medical records sent for his review. Therefore, the physician should be reimbursed for his time at an hourly rate accordingly to his time spend on the case.

9) The proposed DWC change for the Supplemental Evaluations to my opinion should be also reimbursed at the hourly rate. Otherwise, the request should be renamed "Unreimbursed Supplemental Evaluation" and the requesting party should notify the QME physician at the time of the request that the party(es) plan not to reimburse the physician. e.g. alleged violation of 10682(b).

10) The DWC needs to create and administer a dispute resolution process for QMEs to be heard, prior to providing the service, if the physicians disagree with the request to provide an unreimbursed report.

11) An automatic annual COLA increase should be included in the fee schedule.

12) The physician should be required to perform research to substantiate his/her opinion and should be able to bill by the hour to fortify the final diagnosis and recommentdations.

However, without additional legislative help and due to the duplicity of the current DWC regs, it will only happen thru the legal, political route. I also believe that money should

be spent in the legal/political realm and provided by our members. With substandard regulations, one will only see substandard reports. I am open to contributing toward the purpose of obtaining legal and political help. The audit apparently fortifies our positions I am told(where does one find the audit results??). I have reviewed the summary of the DWC/payors meeting and cannot believe that the agreements were not accepted by the DWC/Carriers???

Complexity is a huge part of what orthopedic surgeons generally deal with as multiple body parts and and/or complaints include the bulk of the patient's complaints evaluated. Medical research performed studiously and carefully is more than appropriate as science dictates our physical exam, and treatment recommendations, whether current or especially in the future.

Ariella Reisner, Psy.D. July 9, 2020

The proposed changes are unacceptable and if passed will not allow me to continue being a QME. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is extremely disappointing that DWC has undercut these levels and is attempting to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

The reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

I will honestly not be able to continue to be a QME if the proposed changes are passed. Being a QME is something that I have done with great pride for approximately the past 10 years. I put my heart and soul into every report that I write, but I will not be able to continue to do this if I will be earning considerably less money. Many of my cases are extremely complex and require extensive time and attention. Reducing the QME fees will make it difficult for me to continue to perform quality evaluations and I will be forced to resign as a QME.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Leonard Gordon MD July 9, 2020

The new proposed fee schedule has been circulated in recent weeks and after studying the details, several problems have become evident to me. It is urgent that a new agreed-upon fee schedule be adopted in a timely fashion. Some years ago, when regulations for treating physicians and surgeons were changed without debate or input from providers, many of my well-trained and competent orthopedic and, especially, hand surgeons decided to no longer treat injured workers for multiple reasons; the paperwork became too cumbersome, reimbursement too low and all control landed in the hands of the employer. This sparked a new "industry" called independent medical review at considerable expense and with marked inequities; reviewers even now are at times paid more than the treating surgeon. If we do not adopt fair, equitable payment for medical-legal services, the already depleted numbers of providers doing this work are very likely to dwindle further as occurred with treating physicians and surgeons. I can tell you as an AME that when I try to find a competent hand surgeon willing to care for workers' compensation patients in a particular region, it is most often a frustrating and fruitless endeavor.

I have been advised of the agreed-upon parameters between stakeholders that resulted from many months of meetings; I am hopeful that the DWC will adhere to these parameters. In the interest of brevity, I will mention 5 of the more important ones.

1 - A re-evaluation should be billed up to 9 months from the initial evaluation as at that point, the facts have usually changed, the examination of the patient needs to be completely redone and, by then, there are often significant additional medical records to be reviewed. The DWC has proposed that an evaluator must bill as a re-evaluation up to 2 years after the initial evaluation, ignoring the changes that are well known to occur to a patient over a 9 to 12 month period.

2 - There has been considerable discussion regarding payment for record review. Creating a reasonable, fair and consistent time-based or page-based system should be eminently possible. This was agreed upon, but the agreement has, to my understanding, not been followed.

3 - Records must be sent in time for the evaluation. One reason I can do an efficient job is that I dictate my report without using templates on the day of the evaluation when it is completely fresh in my mind. Receiving the records late hinders the continuity of information flow and precludes obtaining information from the patient as it relates to the

records. The process of incorporating the newly arrived data into the complex analyses and opinions already formed increases the difficulty of preparing the report and diminishes its accuracy. Records must arrive at least a week prior, or they should be reported by the evaluator in a separate supplemental report and charged independently. The requesting party should count the pages, so there is no question of incorrect numbers or billing.

4 - AME evaluations are more complex in all respects and carry an added amount of responsibility and knowledge; all such services should be reimbursed at a higher level.

5 - An automatic COLA increase should be built in, especially if one considers how difficult it is to get a rate increase by the current process; notably there has been no rate increase for 16 years.

I have always treated injured workers, even while in academics as Chief of Hand Surgery in the Department of Orthopedic Surgery at UCSF, and believe well-trained doctors need to be in the workers' compensation system. As my son joins me in practice as a hand surgeon trained at the University of Pennsylvania and with an advanced fellowship at the University of Washington, he and I would like him to become involved. We both believe in the dignity of workers. Without fair recognition of the medical-legal work done, it is difficult to recruit new doctors or even hold on to established ones, and the quality of the work declines or, in some areas, becomes unattainable. Our system in California has gone from being one of the best providers of treatment for injured workers in the US to one in which injured workers often have great difficulty accessing good care. At the same time politicians claim that the system has now been "corrected."

Please make sure that the promise made to injured workers is not further eroded.

Emily Ziegler, Psy.D., Q.M.E. July 9, 2020

I wrote to express my concerns after the first proposed fee schedule and, although this second proposal moves in the right direction, I am still disappointed and concerned about my ability to continue as a QME. I am a psychologist and have functioned as a QME since 2011. I thoroughly enjoy this work as each case is quite unique and presents learning opportunities related to other fields. I wish that enjoyment was adequate compensation but such is not my luck.

As the DWC is well aware, psychiatric and psychological evaluations are by definition more complex and take a great deal more time in most cases. The current billing code recognizes this by allowing a single complexity factor to all psych evaluations at baseline. The current proposal uniquely damages psychiatric and psychological

evaluators who have been performing complex and lengthy evaluations that will not be reimbursed adequately under the current proposal. The current flat-rate fee also incentivizes sloppy, incomplete evaluations. This will likely result in attrition of skilled and experienced mental health evaluators which will adversely impact injured workers. The current proposal is imbalanced because it favors a raise for certain specialties while issuing a pay cut for psychiatrists and psychologists. Mental health evaluations make up approximately 10% of QME panel requests and compensating mental health evaluators adequately will not significantly financially stress the current system/budget. I do not know that I will be able to continue as a QME if the current proposal is passed. I agree with CSIMS in their response to the current proposal. The agreements made in the stakeholder meeting were not followed and should not be walked away from.

I think it is entirely fair, reasonable, and in-line with the minimum requirements for a psychological evaluation to use a 3x modifier. The 3x modifier must be applied to all psychiatric and psychological reporting, including initials, re-evaluations, and supplementals. With three times the required examination time, which is almost always exceeded, a modifier of only .5 is not adequate. It is illogical that some pages are worth more than others. In fact, I would argue that a rising page count is a reliable indicator of case complexity. Decreasing compensation for complex cases just doesn't make sense.

In summary, a proposed pay cut for psychologists and psychiatrists on the heels of no pay raise or COL increase for over a decade is just unconscionable on the part of the DWC.

Scott M. Thompson, CEO July 9, 2020
Arrowhead Evaluation Services, Inc.

The changes proposed by the DWC are a good first step towards improving the fee environment for most physicians performing medical legal evaluations in the workers' compensation arena.

I was a member of the stakeholder group that met several times at the Oakland DWC, and I feel that much progress was made during those meetings between payers and providers. I thank the DWC for accommodating us and for providing a face to face forum.

It's important to note that the DWC has made it clear that its intention is to make the MLFS a flat fee structure with modifiers. An hourly / complexity-factor system has been viewed as problematic, and open to abuse by both providers and payers. Thus, I believe that to advocate for an hourly-based system is a waste of time, as one of the DWC's worthy goals is to reduce friction, and an hourly-based system invites abuse.

The proposal, as written currently, remains problematic in many ways, but is salvageable as long as the DWC is able to make key changes. As we can all see from the submitted comments thus far, the 1.5 modifier for mental health evaluations is inadequate. There were many providers at the stakeholder meetings that stated as much. In March, just prior to the COVID shutdown, myself and others representing mental health providers made a special trip to meet with DWC regulators in Oakland to appeal for a higher modifier. We pointed out that such specialists typically spend far more time than, for example, an orthopedist when taking a history and exploring mental health issues. Many psychologists and psychiatrists only schedule one evaluation per day, and most that I have worked with spend at least two hours face to face. Thus, a 1.5 modifier for mental health almost seems like punishment for performing evaluations that payers don't necessarily want to see. (As a former claims adjuster, I can attest that mental health claims are certainly frustrating to deal with because of the subjective nature of the claim itself.) Regardless, these are typically very complex cases and are routinely extraordinarily complex for the evaluator, as expressed throughout the comments to this forum. A more reasonable modifier for mental health evaluations would likely be 2.5. Similarly, neurology and internal medicine evaluations are more time consuming, though not usually comparable to mental health evaluations and these deserve a modifier in the 1.5 range.

There were a few changes in the written proposal that came as a surprise to those of us who participated in the stakeholder meetings. These have been detailed in the comments made by many providers. In addition to the above recommendations, I recommend the following:

- All pages over 200 should be reimbursed at $3/page (Note: The reduction to $2/page was not agreed to in the stakeholder meetings)

- Pages should not be legal sized, only standard sized (Note: This will reduce friction.)

- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation (Note: This will reduce friction.)

- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages. (Note: doctors and their staff should not have the burden of counting pages.)

- The fee schedule should include an automatic annual COLA increase for QMEs. (Note: Part of what created the current contentious environment is the lack of an

automatic adjustment. At the rate in which our federal government is increasing the money supply, we should all anticipate inflation.)

- The mental health modifier should be increased to at least 2.5x
- Research is useful in some specialties and there should be a mechanism to incorporate and pay for research, limited to two hours, or perhaps more if authorized by the payer. (This would be especially helpful in toxic exposure and neurological conditions.)
- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i). (Note: all of these minor changes would reduce friction.)
- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation, not the date of issuance of the report.
- The way in which an unreimbursed "remedial supplemental evaluation" is troublesome. The requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. The scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b).
- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.
- Neurology and Internal Medicine evaluations are typically more complex and time consuming and deserve a 1.5x modifier

Overall, the stakeholder meetings that the DWC hosted were productive, cordial, and I am grateful that the parties were able to meet face to face and exchange ideas before COVID swept over our state and nation. Too much work has been put forth to simply say “scratch everything and start over”. Rather, the DWC can make some necessary

changes and hopefully we can meet the goal of having a viable new Medical Legal Fee Schedule in January 2021 that may not please everyone, but is more respectful to mental health providers, reduces friction and headaches for payers/doctors/judges, incentivizes doctors to become QMEs, and most importantly, provides quality reporting that serves injured workers.

Steven W. Meier, M.D. July 9, 2020

Diplomate of the American Board of Orthopedic Surgery

Qualified Medical Examiner

I appreciate the opportunity to comment on the recently proposed changes to the California Medical Legal Fee Schedule. I am a QME and a member of CSIMS and the COA. I have performed many AMEs and QMEs over the past 10 years. I believe that the current medical legal fee schedule is in need of revision. I think the effort to adopt a more straightforward fee schedule will be beneficial to all parties.

I am aware that CSIMS and other provider groups have met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on a number of key terms. However, I was dismayed to learn that the latest version of the proposed new fee schedule is not consistent with the terms that were mutually agreed upon in the QME stakeholder process.

In the stakeholder meeting, there was an agreement that the reimbursement for record review would be $3.00 per page starting on page 201. However, that was changed to $2.00 per page starting on page 2001. I do not understand the rationale of this since the amount of work does not decrease as the number of records to review increases. The concept of a bulk discount” does not apply to medical expert work. Therefore the agreed upon value of $3.00 per page should not be limited based on the total number of pages.

In the stakeholder meeting, there was an agreement that the definition of re-evaluation should be an exam occurring within 9-12 months of an initial evaluation. However, this was then changed by the DWC to 24 months. Why would this change be warranted in a way that appears to benefit one party over another after it was already agreed upon by the stakeholders?

I agree with the AME modifier of 1.35x. AMEs have earned the agreement of the parties versus being the “last person standing” of the pQME striking process. It is reasonable for AMEs to be compensated more as the parties place a higher value on their reports. This should be beneficial to the workers compensation system by incentivizing QMEs

to strive to earn AME work by producing higher quality reports that consistently qualify as substantial medical evidence. But this AME modifier should apply to all services including the review of records and depositions as agreed upon by the stakeholders, not only the flat fee for reports.

And finally, including an Automatic Annual COLA Increase would only be reasonable. The current fee schedule stagnated for years without any increases to reflect the progressive increases in general cost of living. Examples for this would be the DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.

The data shows that the need for QMEs in the workers compensation system is increasing while the number of QME doctors is dwindling. There is a perception by young doctors that this important work is not rewarding and too much of a hassle and therefore many are reluctant to become QMEs. This is only going to exacerbate access problems, creating further hardship for injured workers. It is important to compensate QMEs for their work fairly to attract new physicians to this field.

I hope these comments are helpful for the ultimate rule making process. I look forward to seeing the adoption of a new fee schedule that will ultimately be beneficial to the injured workers of California.

Mariya Kopynets
Office of G. Charles Roland, MD
Orthopedic Surgeon
July 9, 2020

Please consider the following:

1) the Deposition reimbursecement should be introduced at $455 per hour, billed at the minimum of two hours for the Deposition appointment (one hour for records review and one hour for fate-to-face meeting with the parties).

2) if the Deposition is canceled 8 business days prior to the scheduled appointment, there is a $455 reimbursement fee for a non-timely cancelation.

3) the sub rosa videos must be provided to the QME doctor prior to the patient’s evaluation. The sub rosa video is an additional cost $325 per hour for the physician to review.

4) there is a proposed $325 per hour reimbursement rate, instead of the $250 that is billed now for all ML104 and ML106.

5) all the medical records and Cover Letters must be provided 3 weeks prior to the patient's evaluation. Otherwise, the medical records will be included in the newly-generated Supplemental report.

6) at the time the appointment is scheduled, the parties are requested to list the total number of medical records they are sending to the QME physician for his review. This ensures there is no discrepancy during the reimbursement process by the insurance carrier.

7) the Complexity factors should remain in place, as the report will take much longer to complete for a patient with multiple injuries for multiple body parts at multiple prior employers.

8) The Supplemental reports should continue being reimbursed at the hourly rate, as it serves as a direct response of the QME physician to the questions posed by the parties in the Cover Letter.

The supplemental report also is generated when new medical records are sent for the physician to review. In all cases the QME physician dedicates his time to address the questions posed by the parties and or to review the medical records sent for his review. Therefore, the physician should be reimbursed for his time at an hourly rate accordingly to his time spend on the case.

9) The proposed DWC change for the Supplemental Evaluations to my opinion should be also reimbursed at the hourly rate. Otherwise, the request should be renamed "Unreimbursed Supplemental Evaluation" and the requesting party should notify the QME physician at the time of the request that the party(es) plan not to reimburse the physician. e.g. alleged violation of 10682(b).

10) The DWC needs to create and administer a dispute resolution process for QMEs to be heard, prior to providing the service, if the physicians disagree with the request to provide an unreimbursed report.

11) An automatic annual COLA increase should be included in the fee schedule.

12)The physician required to perform research should be able to bill by the hour.

Jacob Rosenberg MD FACPM, FABAN, QME
President CSIMS

July 9, 2020

The California Society of Industrial Medicine and Surgery (CSIMS) submits the following comments on the DWC Forum concerning Reimbursement of Medical-Legal Expenses Regulations:

Introduction

The DWC *Newsline* No.: 2020-56 dated June 25, 2020, indicates that the proposed revisions to the Medical-Legal Fee Schedule (MLFS) attempt to establish the following goals:

"The implementation of a predominantly fixed fee for all procedure billing codes is anticipated to reduce frictional costs. Moving to a flat-fee-based schedule and removing complexity factors is contemplated to reduce the incidence of disputes over billing."

A careful review and analysis of the proposed revisions leads CSIMS to the conclusion that the stated goals will not be satisfied. Rather than "reducing frictional costs," the provisions on remedial reports will intensify the adversarial relationship between providers and payers. Inadequate reimbursement will lead to a further decline in available QMEs.

DWC last adjusted the medical-legal fee schedule in 2006. Since that time, the workers' compensation system in California has become much more complex. This additional complexity, which has come by way of new case law and a substantial increase in the number of medical records reviewed per case, has directly impacted QMEs and AMEs. The average case requires significantly more time and expert analysis than 10 years ago. As such, we believe that a substantial increase in compensation to medical-legal providers is warranted in order to a) adjust reimbursement for the past 15 years of inflation and b) reflect today's more complex medical-legal environment as compared to 2006.

The DWC has now published 3 fee schedule proposals In May of 2018, DWC released a fee schedule proposal after the settlement of the *Howard v. Baker* case. After negative comments the proposed schedule was abandoned.

In August of 2019 DWC offered a completely different fee schedule structure removing complexity factors with reimbursement set as a flat rate plus a per page fee for medical records. Analysis suggested tis would not result in a raise for the majority of QMEs. After mostly negative comments by QMEs this proposal was also abandoned.

The current proposal is partially a response by the Division to the publication of Report 2019-102 by the California State Auditor. The report entitled "Department of Industrial Relations: Its Failure to Adequately Administer the Qualified Medical Evaluator Process May Delay Injured Workers' Access to Benefits." described numerous systematic failures by DWC to properly administer the QME system including:

- DWC has not taken sufficient action to address its QME shortage. For example, *it has not taken one key step that could help it attract and retain QMEs: updating the rates of its medical-legal fee schedule*—the fee schedule QMEs use to charge for their services. This fee schedule's rates have not been updated since 2006. *However, state law requires DWC to adopt and revise the medical-legal fee schedule in tandem with its Official Medical Fee Schedule (OMFS), which establishes reasonable maximum fees paid for specific workers' compensation medical services. Although DWC updated the OMFS multiple times from 2014 through 2018, it has not updated the rates in the medical-legal fee schedule for QMEs in 13 years.* **According to the administrative director, DWC has not done so because of limited resources.** Consequently, QMEs are billing for their services at 2006 rates, which are much lower than what the rates would be if they had kept pace with inflation. (emphasis added)

- Although DWC is responsible for overseeing QMEs and administering the process for selecting QMEs to examine workers, it has not adequately ensured that it has enough QMEs to keep up with the demand for their services.

    - From fiscal years 2013–14 through 2017–18, the total number of QMEs available decreased by 12 percent and requests for QME services increased 37 percent.

- DWC inappropriately used its reappointment process to discipline some QMEs alleged to have committed overbilling violations, which raises due process concerns.

    - DWC lacks sufficiently detailed, written policies and procedures for investigating and resolving complaints.

- DWC has not continuously reviewed QME reports for quality and has not tracked when workers' compensation judges have rejected QME reports that failed to meet minimum standards.

    - Low-quality QME reports can delay injured workers' receipts of benefits and add expenses for employers involved in disputes.

Unfortunately, the current proposal by DWC would result in lower compensation for complex reports rather than increase compensation as suggested by the auditor. The importance of producing high-quality medical-legal reports that constitute substantial medical evidence, especially in complex cases cannot be overstated. Any revisions to the MLFS should aim to enhance, not reduce, the quality of these reports.

Before getting into the details of the proposed fee schedule, we would be remiss if we did not point out that the fee schedule proposed by DWC ignores and

undermines much of the work done in stakeholder meetings. DWC hosted stakeholder meetings between QMEs, QME groups, and insurance carriers from the fall of 2019 through January of 2020. CSIMS was present at each of these meetings. The outcome of these meetings was a consensus between the stakeholders on the nature and substance of a new fee schedule proposal. We are disappointed that the present proposal from DWC does not accurately reflect the consensus that was found at the stakeholder meetings. Instead, this proposal materially modifies that consensus in favor of insurance carriers. Every DWC change made to the stakeholder consensus fee schedule solely benefits insurance carriers. These actions undermine the integrity of the stakeholder process and calls the neutrality of DWC into question. Based on the prior conduct of DWC and the findings of the State Auditor's report, it is surprising that DWC yet again chose to violate the trust of the QME community solely for the financial benefit of insurance carriers.

We must note that the phrase, **We raised this issue last year in our submitted comments and since then but it has been consistently ignored by DWC."** Occurs multiple times in these comments. We point this out for two reasons. First, we underscore that we continue to go in circles for years discussing the same issues but no progress has been made. Simply put, DWC continues to promote fee schedules favorable to payers. Even when presented with a consensus fee schedule devised with payer input, the DWC could not simply publish the consensus. Urgent action is needed as QMEs continue to leave the system. We encourage DWC to read these comments and take appropriate action swiftly.

Second, we include this phrase to demonstrate the level of frustration experienced by the QME community as a result of DWC's inaction on this issue. The QME community has been clear and vocal with DWC for years about its frustrations with inadequate reimbursement. However, DWC has done nothing about this. Meanwhile, insurance carriers continue to enjoy record profits in the California Worker's Compensation market. These record profits have been subsidized by DWC's actions on a variety of issues including QME pay, MPN regulation and utilization review regulations. All of these actions or inactions benefit payers. DWC's action ultimately harm injured workers and are in direct contravention of DWC's self-proclaimed mission to "minimize the adverse impact of work-related injuries on California employees ..."

Comments on Specific Changes to the MLFS

1. Addition of §9794(a)(1).

The proposed subdivision (1), in effect, provides that "no other charges shall be billed under the Official Medical Fee Schedule in connection with a medical-legal evaluation or report." Although DWC staff indicates that they intend to limit billing under the OMFS to

medical-legal diagnostic tests, the overly- restrictive proposed language could prevent appropriate billing for medical-legal consultations.

Current regulations (§§31.7and32(b))concerning medical-legal consultations are ambiguous and incomplete. If a medical-legal consultation, because of its content, is not eligible for reimbursement under the MLFS, it should be reimbursable under the OMFS. The proposed language of subdivision (1) is defective because a medical-legal consultation is an expense incurred "in connection with a medical-legal evaluation or report" and it is also in conflict with the second paragraph of §9795(a).

We raised this issue last year in our submitted comments and since then but it has been consistently ignored by DWC.

2. ML100/Missed Appointment Fee. The proposed fee schedule contemplates a narrow set of circumstances under which a QME would be entitled to reimbursement for a missed appointment.

Only allows for:

- injured worker does not show up for the evaluation
- injured worker is more than 30 minutes late for the appointment and the QME is unable to continue with the scheduled QME appointment
- appointment has been canceled within six business days of the scheduled appointment date.

Needs to be expanded to allow for:

- injured worker leaves prior to completing the evaluation
- interpreter does not show up for the evaluation
- interpreter leaves prior to completing the evaluation
- evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h)
- evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)

Further, the proposed fee scheduled allows for reimbursement of reviewed records associated with a missed appointment. However, the exclusion of future billing for pages reviewed associated with a missed appointment is poorly worded and too broad.

The language should be revised in order to avoid future disputes and litigation associated with these services.

Currently the proposal states, “Any pages reviewed for this record review report will be excluded from the page count for reimbursement when the face-to-face or supplemental evaluation takes place.”

The proposal should be modified to read,

“Pages specifically reviewed for this record review report will be excluded from the page count for reimbursement if the face-to-face or supplemental evaluation takes place within 3 months of the date of the missed appointment. Notwithstanding the foregoing, any additional pages provided to the evaluator for the face-to-face or supplemental evaluation in addition to the pages reviewed associated with the missed appointment shall be added to the page count for reimbursement when the face-to-face or supplemental evaluation takes place.

3. Threshold of 200 Pages of Records Included in Flat Fee.

DWC proposes a flat fee for Comprehensive and Follow-Up Medical-Legal Evaluations which would be inclusive of the first 200 pages of medical records.

First, the definition of page as defined under the proposed should be changed. In the proposal, under the proposed 9793(n), “For purposes of record review, a page is defined as an 8 ½ by 11 or 8 ½ by 14 single-sided document, chart or paper, whether in physical or electronic form. Multiple condensed pages or documents displayed on a single page shall be charged as separate pages.”

As CSIMS has recommended previously, we offer this alternative, more comprehensive definition of “page:”

- **Page count is based on:**
    - 12-point or larger Times New Roman, Calibri, or Arial font (cover letters)
    - Original font size (medical records)
    - Actual number of deposition pages (i.e. in a condensed deposition that has 4-pages shrunk to fit on each page, each actual page of the deposition is counted – i.e. a 40-page deposition transcript equates to a 10-page condensed deposition transcript à 40 pages would be included in the record count) or require non-condensed deposition transcripts

  - Single-sided and 8 ½ x 11" ONLY (any larger dimensions should be prohibited)

- Duplicates/redundant medical records/UR/IMR/prescriptions, etc. are counted with equal weight including prior reports from the same medical legal evaluator that are sent with requests for re-evaluation or supplemental report(s)

- Parties sending medical records must each declare under penalty of perjury the total page count they sent with proof of service

- Evaluators must declare under penalty of perjury the grand total page count in the report (of all medical records received/reviewed)

- Review of summary reports NOT generated by the evaluator will be counted

- If medical records are sent on CD, then all non-subpoenaed records must be combined in one PDF file (not separate), and each subpoenaed medical record must be in separate PDF files. The subtotal page count for any CD will be based on the number of pages in the PDF files (i.e. if subpoenaed records say 100 pages, but the PDF file is 105 pages, then 105 pages will be counted)

- The evaluator must add all of the records sent from the various parties to achieve a grand total

- If there are disputes related to any portion comprising the total records reviewed, then there needs to be a streamlined adjudication process (either established or new) to address these disputes

We raised this issue last year in our submitted comments and since then but it has been consistently ignored by DWC.

4. DWC proposes reimbursement of $3 per page in excess of the first 200 pages for Comprehensive and Follow-Up medical-legal evaluations and then $2 per page after the first 2000 pages. In the consensus fee schedule, there was agreement that medical records would serve as a proxy for complexity. The DWC and the payers were unwilling to consider alternative mechanisms to identify and reimburse complex reports. Under these circumstances it is inappropriate to reduce fees as medical records increase. To begin with QMEs currently are reimbursed $2.50/page. The $2/page fee is a 20% pay reduction for QMEs imposed on the most complex reports. More records mean more data to analyze and to incorporate into a report.

Third, DWC's proposal does not specify who has the burden for determining the number of pages of records reviewed by the medical-legal evaluator. The proposal states,

"When billing under this code, the physician shall include in the report a verification under penalty of perjury of the total number of pages of records reviewed by the physician as part of the medical-legal evaluation and preparation of the report."

We are led to believe that the burden for page count verification is therefore placed on the medical-legal evaluator. This will certainly lead to friction and litigation due to disputes over page count. Further, placing the burden of such a ministerial task on the medical-legal evaluator is inappropriate. The Parties are tasked with obtaining, collating, preparing and sending the Documents to the medical-legal evaluator for review. As such they are in a much better position to ascertain the correct page count than the medical-legal evaluator who has the Documents dropped in his or her lap.

We propose that the burden of page count verification be placed on the party sending Documents to the medical-legal evaluator for review. Each party should be required, under penalty of perjury, to specify the page count for all Documents sent each time they submit Documents to the medical-legal evaluator for review with a penalty if they substantially misrepresent the number of pages sent for review. Essentially all the documents sent require a review.

The Workers' Compensation system places similar administrative burdens on the employer. For instance, an employer has 90 days to accept or deny a claim. If the employer does not respond within the 90 days, then the claim is deemed accepted. Similar rules exist for utilization review; if the employer does not complete utilization review within a timely manner then the requested treatment is deemed authorized.

Accordingly, we propose that the administrative burden of counting pages of documents sent to the medical-legal evaluator be placed on the parties submitting records. Such a ministerial duty should not be placed on the evaluator. We would point out that the defense clearly has more significant resources at their disposal than any physician. If the insurance company finds it too burdensome to sort the records how can the DWC reasonably require the physician to provide this service on a regular basis,

We raised this issue last year in our submitted comments and since then but it has been consistently ignored by DWC.

5. Flat Fee of $1,316 for Re-evaluations and Definition of Re-evaluation

Of particular concern is that the lower flat fees for re-evaluations appears to be apply to all re-evaluations within 24 months of the initial evaluation. The current structure of the fee schedule wisely recognizes the difference of complexity between re-evaluations occurring prior to or later than 9 months of the prior evaluation. Under the current fee schedule structure, re-evaluations which occur within 9 months of the most recent evaluation are afforded the ML101 code. We propose a re-evaluation be defied as an evaluation requested within 11 months of a prior evaluation and where applicant is

available for a re-evaluation within 60 days. This definition provides an appropriate time frame for reduced complexity and eliminates gamesmanship in scheduling and requesting evaluations.

Alternatively, the DWC can simplify the current proposal by ascribing identical reimbursement for re-evaluations and initial evaluations. Re-evaluations often present substantial complexity and may be more complicated than initial evaluations. Such complexity may involve interval treatment (or denial of same), interval injuries and compensable consequences, all of which may ultimately increase the complexity of analysis of apportionment, AOE?COE, permanent and stationary status, work preclusions, and impairment.

We raised this issue last year in our submitted comments and since then but it has been consistently ignored by DWC.

6. Modifiers For Increased Compensation Not Applicable to Record Review or Deposition Testimony

The Division's proposal indicates that the modifier for AMEs does not apply to per page review fees or deposition testimony

During the stakeholder meetings, all parties agreed that the AME modifier should apply to all evaluations, depositions, and to record review fees. Here is yet another example of DWC violating the agreement to the detriment of providers. The only reasoning for such a proposal by DWC is, yet again, to save costs for insurance carriers. Currently the AME modifier applies to the entire fee. This change therefore represents another pay cut. Further payers do not have to use AMEs. Choosing to use an AME is voluntary. If the fee is to steep then AMEs will see a decrease in volume. Given the advantages in case settlement with an AME it is unlikely that will occur.

We raised this issue last year in our submitted comments and since then but it has been consistently ignored by DWC.

7. Modifier of 50% for Only Psych, Board-Certified Oncologists and Board-Certified Toxicologists

DWC's proposal offers a 50% increase in the flat fee rate for psychiatric and psychological evaluations as well as for Board-Certified Toxicologists and Oncologists. No other specialties are eligible for modifier increases under DWC's proposal.

As discussed, several times over the past years, our position is that other specialties, in particular neurology and internal medicine (and internal medicine subspecialties) are significantly more complex than musculoskeletal examinations and therefore merit increases in reimbursement.

We suggest a 3.0 modifier for psychiatric and psychological evaluations and a 1.5 modifier for internal medicine, pain medicine and neurology.

We raised this issue last year in our submitted comments and since then but it has been consistently ignored by DWC.

8. The Flawed Concept of a "Remedial Supplemental Medical-Legal Evaluation"

The way in which an unreimbursed "Remedial Supplemental Evaluation" is defined is unacceptable and, if adopted as drafted, will result in further attrition of QME physicians from the system.

The DWC should rename this to "Unreimbursed Supplemental Evaluation" to clarify the intent of this "service."

Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this *prior to performing the service*.

Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b).

Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payers or QMEs.

9. No Reimbursement for Medical Research

DWC has not designated any reimbursement for the performance of medical research. Such research is frequently necessary in various instances including cancer cases alleged to be the result of industrial exposure and other areas with complex causation theories. We suggest that the medical-legal evaluator be reimbursed $325 per hour for the performance of reasonable medical research. The QME should explain why research is essential and request a specific number of hours in advance which should then be submitted for authorization.

We raised this issue last year in our submitted comments and since then but it has been consistently ignored by DWC.

10. COLA Omitted

Of significant concern is the fact that DWC has inexplicably omitted any form of COLA increases to the fee schedule in future years. The substantial omission of such a COLA increase is particularly alarming in light of the fact that: 1) DWC was audited by the California State Auditor in part for failing to provide such a COLA increase to medical-legal evaluators since 2006,

2) AB1832 specifically sought to require DWC to include a COLA increase in the medical-legal fee schedule and 3) DWC has proposed a COLA allowance in other recent fee schedule proposals such as the one for copy service providers.

It is disappointing that DWC would omit a COLA adjustment for medical-legal evaluators, thereby guaranteeing that the current fee schedule issues will reemerge within two years.

We recommend that the QME fee schedule be updated automatically on an annual basis based on increases in the DWC's own metric of Statewide Average Weekly Wage.

We raised this issue last year in our submitted comments and since then but it has been consistently ignored by DWC.

11. Premium for late cover letters/medical records

Previously we described how DWC's proposal fails to remedy the significant issue of the parties sending records to medical-legal evaluators in a disorganized and haphazard fashion. DWC's proposal also fails to address another significant issue regarding the medical records: the lateness of the provision of cover letters and medical records to the medical-legal evaluator.

Currently, there is nothing in the QME regulations obligating the parties to send medical records or a cover letter to the medical-legal evaluator with the exception of regulation 34(g) which allows for a mental health medical-legal evaluator to cancel an evaluation due to non-provision of the medical records prior to the evaluation. We strongly encourage DWC to update the QME regulations with language that would hold the parties accountable to providing a cover letter and medical records to the evaluator in a timely manner.

Specifically, we recommend that the parties be obligated to provide a cover letter and medical records no less than 15 business days prior to the evaluation. In the event that these are not provided within the required time frame, the evaluator should be allowed to cancel the evaluation, be reimbursed a failed appointment fee, and be allowed to reschedule the evaluation once provided with the cover letter and medical records.

Alternatively, the evaluator could elect to continue with the evaluation, notwithstanding the late cover letter/medical records, and be paid a reasonable exigency premium specified by DWC in the fee schedule.

Here is another example of where DWC deviated to the agreements reached during the stakeholder meetings. The stakeholders agreed that the parties should be obligated to send records and cover letters to the QME such that they are received by the QME no later than 15 days prior to the date of the scheduled evaluation. For no clear reason, DWC omitted this important term from its proposal.

We raised this issue last year in our submitted comments and since then but it has been consistently ignored by DWC.

12. Electronic Service

Currently, QME Appointment Notification Forms ("ANF") and Medical-Legal Reports are required to be served by mail. This is due to the fact that the proof of service forms (a Declaration of Service accompanying the ANF and QME Form 122 for medical-legal reports) do not allow for electronic service.

We strongly urge the DWC to update these proofs of service forms to allow for an option of electronic service. Each year millions of pieces of paper, toner cartridges, and unnecessary postage are purchased and utilized because of these outdated forms. We have pointed out this environmentally unfriendly and needlessly financially punitive matter to DWC several times over the years but the Division has failed to update these forms nonetheless. We can think of no good reason to continue the status quo and strongly encourage the Division to update service options for QMEs to the 21st century and allow for electronic service.

We raised this issue last year in our submitted comments and since then but it has been consistently ignored by DWC.

13. Notice of cancellation must be sent to QME by parties if they settle/cancel

Currently, QME regulations do not require that the parties inform the evaluator if they have settled the case or if they would like to cancel an evaluation. Frequently the first notice that an evaluator receives that an evaluation is not moving forward is when the injured worker fails to appear for the evaluation. Upon contacting the parties, evaluators are often informed that the case settled weeks ago and that the evaluator was not notified because no such requirement exists in the regulations.

It is time to update the regulations and require that QMEs be informed if their services are no longer needed because the appointment has been cancelled, the case has been

settled or for any other reason. We recommend that the DWC update the QME regs with this requirement.

We raised this issue last year in our submitted comments and since then but it has been consistently ignored by DWC.

16. Notice of objection to QME report must be sent to QME by objecting party

Similar to the previous issue, there is no current requirement that the parties notify the QME that an objection has been lodged to his or her report. Under Labor Code 4622, insurers are required to pay uncontested fees to a QME within 60 days of receiving the report. However, QMEs frequently discover (after 60 days has lapsed) that the insurer will not be reimbursing them because they have objected to the evaluator's report. Frequently, the objection is only sent to opposing counsel but not to the QME.

We strongly encourage the DWC to update the QME regulations to require that a party objecting to a QME's report send a copy of such objection to the evaluator in question.

We raised this issue last year in our submitted comments and since then but it has been consistently ignored by DWC.

17. Underserved Specialty

We believe that a pressing issue facing the QME system is that of underrepresented medical specialties. There are already several specialties for which an injured worker cannot receive a panel due to there being less than the minimum number of 5 QMEs in the entire state of that specialty.

These specialties, to so-called "lost specialties," include Oncology, Infectious Disease, Nephrology, Obstetrics and Gynecology, and Endocrinology.

Several more specialties have significantly fewer providers as a percentage of total provider headcount relative to the demand for their services relative to total system demand. These should be designated as "Underserved Specialties." These include Orthopedic Surgery, Pain Medicine, Physical Medicine and Rehabilitation, and Neurology.

We suggest that DWC provide a modifier and a methodology for identifying and compensating QMEs who are in an Underserved Specialty at a premium rate.

CSIMS appreciates this opportunity to comment on the proposed revisions to the MLFS. In sum, we believe that most of the recommended changes are biased, unreasonable and short-sighted and we urge the Division to consider seriously the comments made herein.

Charles McDaniel July 9, 2020

It is unclear to me how applicants can place their faith in the DWC when the DWC blatantly violates the principles of fair dealing and continues to privilege the interests of the insurance companies over applicants.

The DWC hosted stakeholder meetings between insurance reps and QMEs over the past several months. During those meetings general terms and reimbursement levels were agreed upon. However, the DWC threw those agreements out the window by undercutting the agreements and, again, demonstrates that they are in the pocket of the insurance companies.

As you know, Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal that was endorsed by the QME community. In addition to fee schedules she recommended other qualitative changes that would facilitate the progress on cases. However, in addition to the DWC's disregard for the outcome and the stakeholder meetings, the DWC disregarded nearly all Sue Honor's recommendations, including the qualitative ones. The only group that benefits from delayed resolution of cases is the insurance company, providing evidence, again, that the DWC has been working to benefit the insurance companies and undermine fair resolutions for the applicants.

Many QME's have quit and continue to quit. Many others were forced out by the DWC's retaliatory behavior. The current DWC climate and proposal is untenable.

I recommend that you recognize the current proposal for what it is — blatant pandering to the insurance companies — and replace it with Sue Honor's proposal which already has broad support in the greater QME community.

Andrea R. Bates, MD EdS, MBA July 9, 2020

As the Chair of the Workers' Compensation Committee for the California Psychiatric Association, I have been chosen by the CPA to bring forth concerns about the proposed new fee schedule. I am also a member of the subcommittee for the California Medical Association. I have been doing QME work for nearly 20 years. In my various roles, I have supervised many doctors through the years, and I feel that I have insight into potential outcomes if the new fee schedule goes into effect.

The flawed ratio problem:

The problem with the main determiner of reimbursement being payment for pages is that the time for pages is not adequately correlated to case complexity, at least not for psychiatric cases. Sometimes there are more complex cases without ample “page counts,” and sometimes there are relatively straight forward cases with high page counts. Take, for example, if a person has an extended hospitalization, or if they are a Kaiser patient. Those two situations would involve a lot of pages off the bat.

Add more reimbursement for time spent with the injured worker:

As a doctor, it is important to listen to the person sitting in front of me. Often the injured worker feels as though they take a back seat to the complexity of litigation of workers’ compensation claims. It is important for the QME examiner to take time and listen to the injured worker for about as long as it takes for the person to explain it and not just the bare minimum required. With all the money spent on workers’ compensation processes, at least incentivize the doctor for spending longer than the bare minimum to listen to the injured worker. By the way, when a doctor listens to a patient, for example, satisfaction scores go way up. If the DWC more directly reimbursed face to face time with the examinee, the injured workers would be more satisfied, and the doctors would be able to get a solid understanding of the injured workers’ complaints. The doctors are the faces for the delivery of workers’ compensation health-related services. Thus, can we please also tie payment to how long an examiner listens to the injured worker? That is, reimburse additional payment for each additional minute past the minimum required interview time. At least reimburse the doctor for listening to our injured workers, sound okay?

Consider this additional modifier for psychiatric cases:

My highly complex cases usually involve a poor historian, a complex mechanism of injury, and a person with an involved past psychiatric history. It takes a lot of time to listen to the examinee, and then to sort-out and explain histories in each of the above situations. I spend a lot of hours transcribing the history that an examinee provides. With the new proposed fee system, I am not going to be able to spend the time needed for taking, writing, and analyzing the histories from at least half of the injured workers. Please consider extra time for: (1) a poor historian, (2) a complex mechanism of injury such as personnel cases and trauma cases, and (3) a person with an involved or positive past psychiatric history. For those cases, please consider a multiplier of an additional 0.5 for each of these complexities up to a maximum multiplier of 2.5. For all other psychiatric cases, a multiplier of 1.5 would minimally suffice.

In conclusion, consider:

With the new fee schedule, I think the system is not going to work out because some cases are going to take too long to be able to get done, and the QME will try to

oversimplify it when it is not possible to do so effectively. A lot of injured workers will subsequently be upset because their doctor did not listen to them, even if some of us will listen to them, there will be too much pressure to abbreviate the patients' accounts due to the time demands upon most doctors. Please consider the extra reimbursement for time spent with the injured worker and additional modifying factors for some complex psychiatric cases.

Alexis Link, MD
Co-Director and CEO
Grand & Quincy

July 9, 2020

Patrick Link, MD
Co-Director and CEO
Grand & Quincy

Please find attached our comments on the proposed MLFS. Our company assists 11 psychiatrists who perform QME/AME evaluations. Our comments include data from an analysis we conducted of how the proposed MLFS would have affected our gross revenue from QME/AME activities during 2019, had it been in place. We have included an Excel spreadsheet that contains our analysis. **[Analysis provided upon request.]** All applicant data has been deidentified using randomly generated IDs.

Our analysis shows that the proposed MLFS would result in a significant cut to the reimbursement psychiatric medical-legal evaluators can expect to receive from their work in the California workers' compensation system: specifically, 9% less gross revenue and 25% less net profit. This would be counter to the stated goals of the stakeholder process in which physicians participated in good faith. We hope it is not your goal to cut reimbursement for psychiatric medical-legal work in the system and that you will change the proposed MLFS to ensure psychiatric reimbursement is improved, as it has not changed, even to account for inflation, since 2006.

We respectfully request that the proposed MLFS be changed in at least the following two ways:

1) The modifier for psychiatric medical-legal evaluations should be increased to at least 2.0.

2) An automatic cost-of-living adjustment, tied to inflation, should be included in the new MLFS.

These are the minimum acceptable changes necessary to ensure the new MLFS does not result in worse reimbursement for psychiatric medical-legal evaluators, both in the near future and over time.

We hope our comments, data, and analysis are helpful as you consider revisions to the MLFS. Thank you for considering them.

Contents of enclosed letter below:

Our company provides training, administrative support, medical billing, and furnished office space to psychiatrists performing medical-legal evaluations in the California workers' compensation system. We support eleven psychiatrists who collectively perform over 250 medical-legal services within the system per year.

We have reviewed the most recently proposed changes to 8 CCR §§ 9793 – 9795 and have concluded that, if implemented, they would result in a significant cut to the reimbursement psychiatric medical-legal evaluators can expect to receive from their work in the California workers' compensation system.

We applied the proposed Medical-Legal Fee Schedule (MLFS) to all the medical-legal bills we submitted for reimbursement during 2019, and we compared the amounts we would have billed under the proposed MLFS to the amounts we billed under the current MLFS. The proposed MLFS would have resulted in 9% less reimbursement for our services.

We investigated what a 9% reduction in reimbursement would do to our net profit after accounting for expenses. If the proposed changes had been in place during 2019, our net profit would have been 75% of the profit we obtained under the current MLFS.

The proposed MLFS would cut our gross income by 9% and our net profit by 25%.

This is unacceptable.

We investigated potential changes to the proposed MLFS to determine their likely effects on reimbursement for psychiatric medical-legal workers' compensation services. Our analyses indicated the following:

- A psychiatry modifier of 2.0 (vs. the currently proposed 1.5 modifier) would result in a roughly 7% increase in overall reimbursement for psychiatric medical-legal services. A psychiatry modifier of 2.5 would result in a roughly 22% increase in overall reimbursement. A psychiatry modifier of 3.0 would result in a roughly 38% increase in overall reimbursement.

- Reimbursing all records above applicable thresholds at $3 per page (vs.

reducing reimbursement above 2,000 pages to $2 per page, as currently proposed) would result in a roughly 4% decrease in overall reimbursement for psychiatric medical-legal services. This is better than the currently proposed MLFS, which would result in a roughly 9% decrease, but it remains a decrease. Most importantly, changes to the psychiatry modifier are far more impactful than reimbursing all records above applicable thresholds at $3 per page.

The Auditor of the State of California's November 2019 report, "Department of Industrial Relations: Its Failure to Adequately Administer the Qualified Medical Evaluator Process May Delay Injured Workers' Access to Benefits," showed that from fiscal years 2013-14 through 2017-18, the number of medical-legal evaluators decreased by 12% while requests for medical-legal evaluations increased by 37%, resulting in unnecessary delays in parties obtaining medical-legal evaluations. Inadequate reimbursement for medical-legal evaluations was listed as a potential driver of evaluators leaving the system. The proposed MLFS may result in overall increases in reimbursement for some specialties, partially addressing the concerns of the Auditor; however, by cutting reimbursement for psychiatric medical-legal evaluations, the proposed MLFS will reduce access to psychiatric medical-legal evaluations, worsening the Auditor's concerns within that subset of evaluations.

The proposed MLFS also does not include automatic cost-of-living adjustments or similar mechanisms to automatically increase reimbursement tied to inflation. In its response to the Auditor's report, the Division of Workers' Compensation (DWC) noted, "The imposition of an automatic increase in the schedule tied to inflation could lead to negative consequences for the overall costs of medical-legal services in the workers' compensation system." DWC further stated, "Whether or not to adjust the fee schedule up or down at any given time should be left to the discretion of the Administrative Director, and not tied to an automatic increase." With respect to the Administrative Director (AD), the fact that the MLFS has not been adjusted since 2006 suggests that the AD reviewing the MFLS every-other-year is unlikely to lead to changes in the MLFS without automatic increases being included. Additionally, the WCIRB's recent report, "2019 California Workers' Compensation Losses Expenses," showed that medical-legal evaluations account for only 6% of the medical losses incurred by payors in the system. Including an automatic cost-of-living adjustment in the MLFS is highly unlikely to cause payors to incur unreasonable costs for medical-legal services. Of note, the value of $1 today is worth roughly 79¢ in 2006 dollars. As such, because the MLFS has not been adjusted since 2006, the value of reimbursement included in the MLFS has effectively been cut by 21% by not automatically adjusting for inflation.

We respectfully request that the proposed MLFS be changed in at least the following two ways:

1. **The modifier for psychiatric medical-legal evaluations should be increased**

to at least 2.0.

2. **An automatic cost-of-living adjustment, tied to inflation, should be included in the new MLFS.**

These are the minimum acceptable changes necessary to ensure the new MLFS does not result in worse reimbursement for psychiatric medical-legal evaluators, both in the near future and over time.

We enjoy participating in the medical-legal system and take pride in our unique role in the system as fair arbiter psychiatric evaluators. Our goal has never been to increase the number of psychiatrists with whom we work simply to pursue net profits. We work with select psychiatrists whom we train to produce clearly written, efficiently worded, clinically accurate, and legally honest reports. This is the satisfaction of our work, but it requires adequate reimbursement to cover our expenses and to balance the risks of participating in the system. The MLFS must be updated but not in a way that disadvantages psychiatric evaluators and the parties who rely on them.

Michael W. Wells, D.D.S. July 9, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payers and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

Sue Honor's proposal and the accompanying petition can be found here: https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue

Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported

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Rupali Das, MD, MPH, FACOEM
Medical Director
Senior Vice President, Medical Management
The Zenith

July 9, 2020

Sharon L. Hulbert
Assistant General Counsel
Vice President, Med-Legal

The Zenith

We commend and fully support the Division of Workers' Compensation's ("DWC") efforts to develop an objective medical-legal fee schedule that can be timely updated for use in the Workers' Compensation system.

Zenith fully supports the comments submitted by the California Coalition on Workers' Compensation (CCWC). In addition to those comments, Zenith would like to address the following:

1. Quality of Medical Reports
2. Controls on Review of Relevant Records for the QME Report

Quality of Medical Reports:

Core to the entire success of the QME process is the quality of reports. This has not been addressed in the current forum proposal. Therefore, we continue to encourage

the DWC to develop processes to better monitor the quality of medical reports as required under Labor Code 139.2(i) which provides:

> i) The medical director appointed pursuant to Section 122 shall continuously review the quality of comprehensive medical evaluations and reports prepared by agreed and qualified medical evaluators and the timeliness with which evaluation reports are prepared and submitted. The review shall include, but not be limited to, a review of a random sample of reports submitted to the division, and a review of all reports alleged to be inaccurate or incomplete by a party to a case for which the evaluation was prepared. The medical director shall submit to the administrative director an annual report summarizing the results of the continuous review of medical evaluations and reports prepared by agreed and qualified medical evaluators and make recommendations for the improvement of the system of medical evaluations and determinations.

Zenith strongly believes that quality of the medical reports issue should remain a key focus for all parties. Without quality reports, the system will continue to struggle. Therefore, we consider report quality a primary objective and goal of the regulations. We continue to support action in the following areas to increase report quality:

a. Require and establish training and education programs to include specific topics such as elements of a report, proper documentation of an occupational history, use and inclusion of guidelines/medical evidence, use and inclusion of research, and appropriate documentation of a physical exam.

b. Evaluate/monitor QME report quality and provide feedback and remediation suggestions to individual QMEs using objective criteria. Use corrective actions to address ongoing issues.

c. Require that all decisions be evidence-based, including evidence-based causation, apportionment, and prediction of future medical care. Require that medical recommendations provided in a QME report be subject to evidence-based guidelines or other published literature.

Records Review:

Records review continues to be of concern. Two issues appear to be core to the fee schedule, 1) quality of reports; and 2) compensation to the QME. We addressed quality concerns above. While we believe the current proposal will provide fair compensation for reviews, we do believe controls are needed to help avoid potential abuse within the system and unfettered billing for record review and administrative costs. Therefore, we support action along the lines proposed by CCWC in its comments to either cap expenses for record reviews or develop alternative controls to make sure only relevant records are submitted for review by the QME. Zenith also continues to support a

process in which the parties are held accountable for records submitted to the QME for review. Such a process would relieve some of the burden the QME currently faces in reviewing and summarizing records that are simply not relevant to the issues presented. By reducing this burden, the QME will be able to spend more time on relevant issues and focus on the report quality rather than administrative tasks that have little to no impact on the opinions being rendered. To this end, Zenith proposes two possible alternatives:

a. Zenith proposes that a process be adopted in which the payer submit a list of records to the applicant's attorney prior to the QME. The applicant's attorney then reviews the list and is limited to submission of records that have not already been submitted by the payer. This would help reduce duplicate records and the time needed to review and cull out duplicate records. Other alternatives that can continue to be explored are the use of a clearing house or independent third party to remove duplicates and organize records before submitting records to the QME. Zenith continues to support electronic submission of records and electronic tools that can detect duplicate records to help manage this issue.

b. Under Labor Code 4062.3(2) and 8 CCR §41(c)(2), only relevant records are required to be reviewed by the QME. However, there will be times when records are submitted that are not relevant. In those instances, the QME should be required to only list and summarize the relevant records relied on by the QME for their opinions and report. Labor Code 4628(c) supports this approach by noting that the review, outlines and inquiries should be done which are "necessary and appropriate to identify and determine the relevant medical issues." This approach would reduce the time required to summarize records and information that have no relevance to the report. To effectuate this change, a clarification should be made to 8 CCR §41(c)(2) as follows:

> (2) Review all available relevant medical and non-medical records and/or facts necessary for an accurate and objective assessment of the contested medical issues in an injured worker's case before generating a written report. The report must list and summarize all relevant medical and non-medical records reviewed as part of the evaluation

This modification will reduce physician time spent summarizing all records and non-medical materials regardless of relevance. The written summaries of all records that are currently being produced have no relevance to the medical portions of the report and therefore are not useful. This approach also brings the regulations into alignment with Labor Code §4062.3(2) which focuses on the review of relevant medical records. Similar approaches have

been successfully utilized for the utilization review process for years. If there is a concern over documenting records submitted, payers and applicant's attorneys could be required to submit records with a list of all records submitted so that it would be clear what records were submitted while the summary would clearly show which records were deemed relevant and relied upon by the QME for the report.

Michelle Laasi, Ph.D. July 9, 2020

I am a QME, Psychologist, and CSIMS member. The proposed QME fee schedule proposal significantly reduces compensation for psychological/psychiatric QMEs from current levels. The complexity of, and time required for, an adequate psychological/psychiatric examination is not reflected in in the proposed flat rates of reimbursement. Adequate examination will not be compensated.

Injured workers referred for a QME (or AME) with a psychologist or psychiatrist may have been, for example, shot, burned in explosions or fires, watched people die (e.g., burning or melting before them; or mass transit drivers hitting individuals on tracks), been crushed by machinery, fallen from great heights, lost a limb from amputation injury, been assaulted physically or sexually, and/or may present with complex symptoms including associated brain injury and other physical injury as well as pain.

First responders in particular may have experienced extreme trauma exposure repeatedly across many years, with resulting PTSD as well as additional physical injury and/or associated psychological symptoms secondary to injury-related factors other than PTSD. These are individuals who risk their lives for us on a regular basis as part of their jobs.

Injured workers may be severely traumatized and may have difficulty describing their history of injury and experiences during the examination or have difficulty due to anxiety, depression, psychosis, tearfulness, or cognitive problems secondary to brain injury. Some workers may be contemplating killing themselves. Taking a psychological/psychiatric history must be considerate of their experiences and state of mind in order to proceed effectively. Accuracy in interview can take time.

However, the injured worker's description of injury and the history of the injury is only one part of a multi-part comprehensive psychological/psychiatric med-legal examination. Such an examination is required to include multiple elements including a lengthy standard psychological/psychiatric evaluation and history and formulation of DSM diagnoses as well as multiple med-legal determinations regarding causation, disability status, apportionment, etc. If physical injury is present then that must also be

screened for and considered in relation to mental status, and referral made to appropriate specialist QME if needed, if that has not already occurred.

Injured workers deserve adequate psychological/psychiatric examination. And the professionals who examine them deserve adequate compensation given the extensive education and training required to complete the examination.

The following objections to the proposed QME fee schedule are made on behalf of injured workers as well as QMEs. Generally, I strongly object to the current flat fee structure. I strongly recommend that Suzanne Honor's proposal be considered. The fact that Ms. Honor's proposal was apparently not considered is of great concern since it apparently received wide support. If Ms. Honor's proposal is nevertheless not considered, my comments are as follows:

- **The modifier for reimbursement for a Comprehensive Medical-Legal Evaluation by a psychiatrist or psychologist should be increased to <u>at least</u> 3.0x.**
  (vs. 1.5x in the DWC proposal, a significant decrease from current reimbursement)
- **Reimbursement for Follow-up Medical Legal Evaluation by a psychologist/psychiatrist is far too low and should be increased significantly.**
- **Follow-up Medical Legal Evaluation should be defined as being within 9 months.**
  (vs. 24 months in the DWC proposal; much can change in a person's presentation even within 9 months).
- Record review reimbursement per page should be $3.00.
- Definition of a page should be 8 ½ X 11.
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the pages should include a declaration under penalty of perjury attesting to the number of pages.
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation.
- The fee schedule should include an automatic COLA increase for QMEs.
- The cut-off date for QMEs to include records or a sub rosa in a face to face evaluation report rather than in a supplemental evaluation should be the date of evaluation and not the date of issuance of the report.
- The definition of a missed appointment should be expanded to allow for: Injured worker leaves prior to completion of evaluation; interpreter does not show up for evaluation; interpreter leaves prior to completing evaluation; evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker or because the injured worker is intoxicated or otherwise medically unable to complete.

- The “Remedial Supplemental Evaluations” section is unacceptable and unfair to QMEs and should be renamed “Unreimbursed” Supplemental Evaluation. Please refer to the CSIMs recommendations on this point as I am in agreement. I note that I have received cover letters from attorneys that ask extensive and time consuming questions about minutiae or based on supposition. Or medical records are often not received on time to review. Who is to determine if some issue was not adequately addressed previously in a report and therefore a Supplemental report will not be reimbursed?

I hope that these concerns will be considered and that we can all work together to help the injured workers in the state of California.

Michael Russo, D.C., QME July 9, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, Again, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meeting! In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders. Sue Honor's proposal and the accompanying petition can be found here:https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost -of-living state than California. As you know, over the years QME report requirements have become increasing more complex with not only more medical issues to address, but even more legal decisions to consider and include with medical opinion. This results in many more hours spent to produce quality QME reports. We are asked to do more and now for far less reimbursement. This can only have a negative effect on the QME community. Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions toward providers. I have continued to serve as a QME despite all of these

issues. This proposal will be the final straw for many providers, including myself. I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Kelly C. O'Neill, PhD, QME July 9, 2020
Clinical Psychologist

I would like to respectfully request that the DWC provide the supporting data used to reach the conclusions you did for determining the recently proposed Medical Legal Fee Schedule. As a medical expert, it is ingrained in us that an opinion requires supporting data. Where is the supporting data for the proposed changes and reduction in compensation for QMEs, notably psychologists and psychiatrists? The DWC disregarded what was negotiated at the shareholder meeting. The DWC disregarded the findings of the RAND study and, in fact, went in the completely opposite direction by giving us a pay cut, rather than the recommended increase. Additionally, it is my understanding that the time allotted to discussing psychology/psychiatry QMEs during the shareholder meeting was appalling inadequate. Please provide the supporting data used for the proposed MLFS.

As a psychologist who has been conducting QMEs for 20 years, I am frustrated and angry at what the DWC has proposed. The proposal no doubt favors and supports the insurance carriers and punishes many medical experts. Each QME I receive gets 100% of my time and undivided attention for many, many hours, from start to finish. I pride myself on being professional, neutral, thorough, and patient with each applicant and each report. This is part of my nature and results in me developing a favorable rapport with each applicant, which, in turn, helps the applicant to be very forthcoming, even if the information shared is not favorable to their case.

With regard to the proposed unfavorable changes to the fee for medical record review, I read each and every word on each and every page of each and every record provided for my review. This is extremely tedious, especially when I receive records a few days before the appointment and I'm up until midnight reading them. I do this because going into an appointment without the roadmap provided by the records can be disastrous for all involved. This level of dedication will be lost if the proposed fee schedule is implemented. Why would I continue to go above and beyond for all parties involved, applicant, defense attorney, applicant attorney, claims adjuster, and insurance carrier? The proposed fee schedule clearly reflects that my time and mental energy are not of value to the DWC. I will not dedicate myself to a system that appears, at least from my vantage point, to be partial to the insurance carrier whose bottom line appears to be saving money, not saving the quality of lives of legitimately injured workers who have

been injured on the job and have no other recourse but to pursue help through the Workers' Compensation system.

When did the DWC decide to align with the insurance carrier rather than maintain a neutral stance between all parties involved in the Workers' Compensation system? The proposed flat rate fee schedule will result in flat reports. The reports will be cookie cutter, template-driven, and more likely than not, inadequate. I am writing to request that the DWC keep the current fee schedule and that consideration be given to providing us with the COLA increase we have been deprived of for many years.

Stacy L. Jones, Senior Research Associate July 9, 2020
California Workers' Compensation Institute (CWCI)

Recommended revisions to the proposed regulations are indicated by underscore and ~~strikeout~~. Comments and discussion by the Institute are identified by *italicized text*.

Discussion and Critical Recommendation:

The per-page records review charge is an integral component of these proposed regulations. During the stakeholder meetings held over several months, all participants recognized that a per-page charge could only be implemented if made in conjunction with a Records Organizer that would act as a clearinghouse and gateway. The Institute understands that the Division may believe that it does not have sufficient authority to regulate a new process such as this, and that formal legislation would have to be enacted. Because of the current health pandemic, the legislative appetite for a new bill at this late stage is not clear. Accordingly, the Institute urges the Division to include a "sunset" clause in these proposed regulations, in order that the per-page charge might be tested and withdrawn if it is indeed unworkable without the Records Organizer concept being implemented concurrently.

§ 9793. Definitions.

(c)(2) performed by a panel-selected Qualified Medical Evaluator, by an Agreed Medical Evaluator, or by the primary treating physician upon agreement of the parties, for the purpose of proving or disproving a contested claim, and which meets the requirements of paragraphs (1) through (5), inclusive, of subdivision (h).

Discussion:

A longstanding concern has been the utilization of the medical-legal fee structure by treating physicians. A regulatory limitation is needed to curtail this practice in order to avoid disputes as to whether a treating physician's report is medical-legal in nature.

Accordingly, the Institute suggests new language that provides clarity to treating physicians wishing to bill for their services under the Medical-Legal Fee Schedule.

§ 9795 Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony services rendered prior to January 1, 2021.

§ 9795.1 Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony services rendered on or after January 1, 2021.

Discussion:

The proposed amendments to § 9795 do not include instructions or codes for services provided prior to January 1, 2021. The proposed code descriptions and fees vary substantially from those currently in effect under § 9795 and warrant a separate subsection for clarity. The Institute recommends a clear demarcation in the regulatory structure based on service date.

(b) The fee for each evaluation is calculated by multiplying the relative value by $16.25 and adding any amount applicable because of the modifiers permitted under subdivision (d). The fee for each medical-legal evaluation procedure includes reimbursement for the history and physical examination, review of records, preparation of a medical-legal report, including typing and transcription services, and overhead expenses. ~~The complexity of the evaluation is the dominant factor determining the appropriate level of service under this section; the times to perform procedures is expected to vary due to clinical circumstances, and is therefore not the controlling factor in determining the appropriate level of service.~~

Discussion:

Considering the flat fee payment structure, language describing payment based on complexity and time must be deleted from subdivision (b).

(c) Medical-legal evaluation reports and medical-legal testimony shall be reimbursed as follows:

CODE	***RV***	***PROCEDURE DESCRIPTION***
ML200	31 ($503.75)	*Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation*. Includes instances where the injured worker does not show up for the evaluation, the injured worker is more than 30 minutes late for the appointment and the QME is unable to continue with the scheduled QME appointment, or in the case

CODE	*RV*	*PROCEDURE DESCRIPTION*
		where the appointment has been canceled within six business days of the scheduled appointment date. If the physician produces a record review report within 30 days of the date of the missed appointment the physician shall be reimbursed at the rate of $3.00 per page for any records reviewed in excess of 200 pages, up to a limit of 1800 additional pages. The physician shall be reimbursed at the rate of $2.00 per page for any records reviewed in excess of 2000 total pages. When billing for a record review report under this code, the physician shall include in the report a verification under penalty of perjury of the total number of pages of records reviewed by the physician as part of the medical-legal evaluation and preparation of the report. Any pages reviewed for this record review report will be excluded from the page count for reimbursement when the face-to-face or supplemental evaluation takes place. Fees for failed appointments and for late cancellations that are incurred through the fault or neglect of the injured worker or his/her representative shall be credited against the injured worker's award.

Discussion:

The Institute's proposed language establishes differential treatment of the fee when incurred through the fault or neglect of the injured worker or their representative.

ML202	81 ($1,316.25)	*Follow-up Medical-Legal Evaluation.* Limited to a follow-up medical-legal evaluation by ~~a~~ the same evaluating physician which occurs within twenty-four months of the date on which a prior comprehensive medical-legal evaluation was performed. The fee includes review of 200 pages of records that were not reviewed as part of the initial comprehensive medical-legal evaluation or as part of any intervening supplemental medical-legal evaluations. Review of records in excess of 200 pages shall be reimbursed at the rate of $3.00 per page up to a limit of 1800 additional pages. Review of records in excess of 2000 total pages shall be reimbursed at the rate of $2.00 per page. When billing under this code, the physician shall include in the report a verification under penalty of perjury of the total number of pages of records reviewed by the physician as part of the medical-legal evaluation and preparation of the report.

Discussion:

For ML-202, all Follow-up Evaluations should be conducted by the same evaluating physician. Also, since a Follow-up Medical-Legal Evaluation may occur after one or more Supplemental Medical-Legal Evaluation reports are submitted, medical records reviewed as part of a Supplemental Medical-Legal Evaluation should not again be eligible for inclusion in the page count for the Follow-up Medical-Legal Evaluation.

ML203	40 ($650)	*Fees for Supplemental Medical-Legal Evaluations*. The fee includes services for writing a report after receiving a request for a supplemental report from a party to the action or receiving records that were not available at the time of the initial or follow-up comprehensive medical-legal evaluation. Fees will not be allowed under this section for supplemental reports (1) following the physician's review of: ~~(1)~~ information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing a comprehensive medical-legal report or a follow-up medical-legal report; or (2) addressing an issue that was requested by a party to the action to be addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation. Review of records that were submitted by a party to the physician fewer than 10 days in advance of the initial or follow-up comprehensive medical-legal evaluation and that were not reviewed as part of that evaluation shall be reimbursed by the submitting party at the rate of $3.00 per page. Failure to issue a supplemental report upon request because of an inability to bill for the report under this code would constitute grounds for discipline by the Administrative Director or his or her designee. The fee includes review of 50 pages of records. Review of records in excess of 50 pages that were received as part of the request for the supplemental report shall be reimbursed at the rate of $3.00 per page up to a limit of 1950 additional pages. Review of records in excess of 2000 total pages that were received as part of the request for the supplemental report shall be reimbursed at the rate of $2.00 per page. When billing under this code, the physician shall include in the report a verification under penalty of perjury of the total number of pages of records reviewed by the physician as part of the supplemental medical-legal evaluation and preparation of the report.

Discussion:

The Institute suggests a slight alteration of syntax for purposes of clarity. The Institute recommends that additional language be added to require payment for records review to be made by the party who failed to submit the records in a timely manner for the initial or follow-up evaluation, which will incentivize early submission of records to the evaluating physician.

ML204	7 ($~~455~~425/hr)	*Fees for Medical-Legal Testimony.* The physician shall be reimbursed at the rate of RV 7, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. The physician shall be entitled to fees for all itemized reasonable and necessary time spent related to the testimony, including reasonable preparation and travel time. The physician shall be paid a minimum of two hours for a deposition. If a deposition is canceled fewer than eight (8) days before the scheduled deposition date, the physician shall be paid a minimum of one hour for the scheduled deposition.

Discussion:

During the stakeholder meetings, a figure of $425 was suggested by attendees. Inasmuch as the current rate for deposition testimony is $250, a 70% increase in the hourly rate should be sufficient to address the concerns in this instance.

ML206	($0)	~~*Remedial Supplemental Medical-Legal Evaluations.* This code is designed for communication purposes only. It indicates and acknowledges that compensation is not owed for this report. This code shall be used for supplemental reports following the physician's review of: (1) information which was available in the physician's office for review or was included in the document record provided to the physician prior to preparing a comprehensive medical-legal report or a follow-up medical-legal report, (2) addressing an issue that was requested by a party to the action to be addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation, or (3) addressing an issue that should have been addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation pursuant to the requirements for a medical-legal evaluation and or report as required by any provision of title eight, California Code of Regulations, sections 9793, 9794 and 9795.~~

Discussion:

Creation of a code describing a non-payable service will cause confusion and the Institute suggests removing this language.

(g) ~~Nothing in this regulation affects the operation of Labor Code section 5307.6~~ The term "extraordinary circumstances" as set forth in Labor Code section 5703.6(b) shall be limited to evaluations performed in the fields of psychiatry/psychology, oncology, or toxicology, and shall be reimbursed according to the modifiers set forth in this section.

Discussion:

The stakeholder discussion participants were united behind a limitation to the statutory opportunity to circumvent the fee schedule. Following extensive discussion, there was general agreement that "extraordinary circumstances" should be defined as evaluations for psychiatry, psychology, oncology, and toxicology. While the proposed modifiers of -96, -97, and -98 appropriately increase the reimbursement rate for these highly complex, specialized, and underrepresented fields, there needs to be a defined restriction in order to avoid abusive practices.

Alternatively, a change in the Definition section at the outset of these amendments could accomplish the same result.

Spencer Chelwick, Administrator — July 9, 2020
Orthopedic Medical Group of Santa Ana
South Coast Orthopaedics
West Coast Orthopedics

Upon review of the updated medical legal fee schedule, the medical groups of Orthopaedic Medical Group of Santa Ana, West Coast Orthopedics, and South Coast Orthopaedics, take issue with some of the proposed changes. Outlined below are our various concerns and recommendations for improvement.

1. This fee schedule completely lacks appropriate reimbursement for complex cases, for example, professional athletes require head to toe examinations, ratings, and apportionment between numerous teams. These evaluations take excessive time and necessitate additional reimbursement as they often come with little to no medical records. Psychological evaluations and other complex specialties fall into this category as well. **MEDICAL RECORDS ARE NOT A DIRECT INDICATOR OF COMPLEXITY.**
    a. Additional fees should be added for complex apportionment analysis in excess of two injuries or employers.
    b. Additional fees should be added for rating analysis for in excess of two body parts.
2. Regarding the -94 modifier: The AME modifier -94 must be applied to all services pertaining to the evaluation, including the record review page count. Otherwise,

you are again taking a pay cut from the QME systems BEST doctors. AMEs should be rewarded for their benefit to the QME system instead of punished.

3. Regarding ML201: Medical records should be served on the QME 15 days prior to the evaluation. The hard cutoff date for QME's to include medical records in a face to face evaluation report MUST be the date of the evaluation. It is egregiously inappropriate to serve a doctor with medical records up until the report is due knowing they only have 30 days to issue the report in the first place. This is simply not feasible and must be written into the law.
    a. Cataloging and counting all medical records should be the responsibility of the parties serving them, not the doctor. Such totals must be certified under penalty of perjury. If the doctor is forced to index and count them themselves there must be an additional reimbursement for that time.
    b. There should be a fee for all records received without an index or out of chronological order.
4. Regarding ML206: The "Remedial supplemental evaluation" code language is absolutely unacceptable. The only time this code is acceptable is when a doctor makes an error and needs to amend his initial reporting or if he leaves out a required portion of the report for no reason. There is no other reason to deny payment for a VALID medical legal report. This code MUST be limited to ONLY when a physician is alleged to have violated 10682(b) without just cause.
    a. There must be exceptions for when a patient is not yet permanent and stationary. Certain issues simply cannot be addressed until the patient has reached MMI.
    b. There must also be exceptions for when a physician is not provided the appropriate information in advance and CANNOT address certain portions of 10682(b) without that information. (see above regarding service of such records)
5. Regarding ML201, ML202, & ML203: The $2.00 per page over 2k pages is a pay CUT from what QME doctors are currently reimbursed. They have not been given a pay increase since 2006 despite laws demanding differently. The bare minimum increase would require physicians be reimbursed at least $3.00 per page, as agreed upon at the stakeholder meeting. This agreement should be upheld by the DWC.
    a. The workers compensation system has never recognized legal documents, so the page definition must be left at a standard 8 ½ by 11"
6. Regarding ML202: Reevaluations should be left at the current definition of within 9 months. Doctors see many patients annually and cannot be expected to have recall of two years on specific cases.
7. It needs to be written into the fee schedule that there will be an annual COLA increase to prevent this debacle from happening again.
    a. Recommendation is made to use the DWC's State Average Weekly Wage inflationary metric or, the CPI For Medical Care in California

8. Regarding ML200: The definition for missed appointment should be amended to include the following:
    a. If the injured worker leaves before the examination could be completed
    b. If the injured worker is rude or abusive to the QME or staff and the examination could not be completed per 41(h)
    c. If the interpreter for an evaluation does not appear, or does not appear timely

The purpose of the new fee schedule was to draw additional QMEs to an already overburdened system and to finally give existing loyal QMEs an overdue raise. This fee schedule goes directly against both of those core tenants as it includes several pay cuts as well as new codes that will remove reimbursement for VALID medical legal reports. The DWC must take the time to read these comments and listen to its constituents and QME physicians when we say this is not acceptable. At the end of the day, the injured worker will suffer when QMEs are not appropriately reimbursed.

Deborah Sampley, D.D., QME July 9, 2020

I appreciate the work that has been initiated towards updating and improving the ML Fee Schedule.

However after reading the proposal, it is certain to me that the DWC hosted stakeholder meetings that occurred with the QME's, and insurance payors over the course of the last several months. I also understand that numerous adequate ad fair agreements were agreed upon by the parties, but yet when the DWC completed the proposal the agreements were not included.

As a QME for over 20 years, and seeing what actually occurs at the time of the evaluations, it is noted there are many inadequacies in this proposal and some are of critical nature.

1. Re-evaluations need to be within 9 months to one year following the last med-legal examination; not 24 months.

2. There is no reason to have a "remedial supplemental evaluation". It is actually a supplemental report that is not reimbursed upon reading it. It is unacceptable and so unfair to the provider QME's. We should answer questions from the parties without being reimbursed.

3. All pages of record review should be reviewed at 3.00 per page and standard page size only. In addition font size should be no smaller than 10 point. It takes longer to review detailed records at 8 point font or smaller.

4. The definition of missed appointment is not complete. It needs to be expanded to times the interpreter does not show, which happens more frequently than the DWC notices. And when the injured worker leaves before the evaluation is completed. And, when the QME has to discontinue the evaluation due to inappropriate behavior, rudeness, intoxication of the injured worker.

5. Regarding QME's receiving records to include sub rosa should be mandated to be received by the date of the evaluation, not the date of issuance of the report. Commonly you receive partial records, have the report almost completed and then receive late records. If records are not received in a timely fashion by the carrier, a supplemental report is appropriate.

I anticipate changes will continue to be made to the "proposed" fee structure, as presently it is incomplete to many occurrences within the QME evaluation process. Please reconsider your proposal.

Peter Spalding, Network Specialist July 9, 2020
Liberty Mutual Managed Care
Liberty Mutual Insurance

On behalf of Liberty Mutual Insurance, we very much appreciate the Division's work to improve the Medical-Legal Fee Schedule. We welcome the opportunity to help spur improvements benefiting California's injured workers and employers.

In short, we view the proposal as a significant step in the right direction. We would also welcome additional reforms, some of which may require legislative action.

Our data has consistently shown California's Workers Compensation medical-legal evaluations to be unusually costly compared to other states. Unfortunately these added costs have not resulted in higher-quality reports (defined as reports that constitute substantial medical evidence, comply with all applicable rules and regulations, and minimize the need for additional discovery). The Medical-Legal Fee Schedule is one of several important tools that can be used to reduce costs and improve report quality.

In 2019, our data showed that the costs of California medical-legal evaluations accounted for more than 54.4% of the costs of medical-legal evaluations

throughout the United States[1]. This was equivalent to more than ten times that of the next-costliest state, namely New York, which constituted only 5.2% of the national total. (Even those numbers are likely conservative, as they do not include other medical-legal expenses such as copy services, which are also unusually high in California.)

Even within California itself, medical-legal evaluations are unusually costly when compared to other medical services. In 2019, they accounted for 10.5% of total Workers Compensation medical costs in the state[2]. This percentage is also much higher than that of any other state, as the next-costliest states were Hawaii (5.8%), West Virginia (3.7%), the District of Columbia (3.1%) and Maryland (3.1%). The national average was 2.0%.

We understand that the Division of Workers Compensation has received feedback from a variety of stakeholders, and that several other organizations have also studied these issues in detail. In particular, we agree with the findings of the California Workers Compensation Institute's report dated February 28, 2018; and the California State Auditor's report dated November 19, 2019.

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

- **We agree that the Medical-Legal Fee Schedule must be updated to keep pace with inflation, but we recommend that it be done through automatic annual adjustments.** The current proposal only makes a one-time update, which risks falling behind inflation in the future. We recommend tying any future updates to an objective data source.

    - The current fee schedule has been in place since 2006. Medical inflation has been significant since that time, so the current reimbursement rates are effectively well below where they were meant to be. This has resulted in many physicians discontinuing their work as Qualified Medical Examiners (QMEs) which often makes it difficult to schedule a timely appointment, as analyzed in detail in the State Auditor's report. The low reimbursement rates have also

[1] Based on payments made by Liberty Mutual Insurance and its affiliates in calendar year 2019. Note that the codes in the Medical-Legal Fee Schedule are unique to California, so the state's costs are being compared to equivalent codes in other states.

[2] Based on payments made by Liberty Mutual Insurance and its affiliates in calendar year 2019.

resulted in questionable billing practices, as some physicians have attempted to avoid billing under codes ML102 and ML103 (which are paid at flat rates) and instead bill under codes such as ML104 and ML106 (which are paid by the hour).

- Annual adjustments have been successful in other areas of California's Workers Compensation system. For example, Temporary Total Disability (TTD) maximum rates have been tied to the State Average Weekly Wage (SAWW) since 2006, thus allowing injured workers' disability benefits to keep pace with inflation.

- **We also agree that record review should be more clearly addressed in the Medical- Legal Fee Schedule, but we recommend more clearly defining which records should be sent to the examiner.** The current proposal would eliminate examiners' ability to bill by the hour and would replace it with reimbursements for extensive record review. We agree with that in principle, but we recommend addressing the deeper issue of when extensive record review is appropriate.

  - Labor Code 4602.3 outlines which records are to be sent to the examiner, but its language is so broad that it often leads to disagreement. The corresponding regulations in CCR Title 8, Section 35 provide little or no clarification. In practice, this often results in the parties sending all available records to the examiner for review, regardless of whether it is reasonable or necessary on a given case. In some cases this amounts to thousands of pages, which are almost impossible to review within the 30 days allowed by law for a QME report. That, in turn, has caused unnecessary delays, costs, and frustration for all parties.

  - We recommend modifying CCR 35 to establish specific guidelines around what records should be sent, so that extensive record reviews are limited to those cases in which they are truly reasonable and necessary. This would help limit unnecessary costs, while minimizing the unintended consequences noted above.

    - By definition, a medical-legal examination exists for the purpose of proving or disproving a contested claim, pursuant to Labor Code 4620. Therefore, the records sent to the medical-legal examiner should be treated similarly to trial exhibits: they should be organized and curated to illustrate the contested issue(s) and avoid duplicative or irrelevant information. The parties should only be allowed to send extensive records (defined as records beyond a

certain number of pages) upon mutual agreement, or when ordered by the Workers' Compensation Appeals Board or the Administrative Director.

- In addition, certain records should be presumed irrelevant absent evidence to the contrary. The parties should only be allowed to send these records upon mutual agreement, or when ordered by the Workers' Compensation Appeals Board or the Administrative Director. Examples include, but are not limited to, billing records or other administrative records; reports of routine follow-up appointments that show no change in diagnosis, prognosis, work status, or treatment plan; physical therapy notes; and medical history unrelated to the contested issue(s) on the claim.

- **We recommend that the fee schedule more clearly define when a treating physician can bill a medical-legal code, as opposed to a treatment report code such as WC004.**

  - The existing fee schedule contains no language around this, nor does the current proposal. The main legal authority on this issue is the above-noted Labor Code 4620 as well as Labor Code 4621. However, that language is also very broad and is difficult to apply in practice.

  - We often see physicians billing medical-legal codes for things like Utilization Review (UR) disputes, claiming that they meet the definitions in Labor Code 4620-4621. This appears to run counter to the intent of Labor Code sections 4061 and 4610.5, which state that UR disputes are to be resolved through Independent Medical Review (IMR) and expressly cannot be resolved by a medical-legal examination. We also see a small subset of physicians providing ongoing treatment on denied claims and billing for a separate medical-legal examination for each visit.

  - This ambiguity risks becoming a significant area for abuse, given the increased reimbursements under the proposal. Under the current fee schedule, the maximum reimbursement for a treatment report code, absent mutual agreement, is $181.48 for code WC004. The reimbursement for a basic medical-legal examination is currently $625.00 for code ML102, while this proposal would increase it to $2,015.00 for the new code ML201. In other words, without clear guidelines in place, an unjustified medical-legal code could inflate the reimbursement rate more than tenfold.

- To avoid these abuses, we recommend adding language to the medical-legal fee schedule stating that treating physicians can only bill medical-legal codes under limited circumstances to prove or disprove a contested claim. They should not be allowed to bill medical-legal codes for UR disputes or other issues that are expressly barred from medical-legal examinations, nor for ongoing treatment. When treating physicians do bill medical-legal codes, only the initial medical-legal evaluation should be billed as a comprehensive medical-legal evaluation.

We also see opportunities for improvement in other aspects of medical-legal evaluations, which fall outside the scope of the fee schedule. For example, we recommend more rigorous quality controls and a more streamlined process. We recognize that some of those reforms would require legislative action, which we would support. Our goal in this area is to improve medical-legal report quality while reducing cost, which would be a win-win for both injured workers and employers.

Diana Cloos, Regional Account Executive July 9, 2020
Director of Education
Workers' Compensation Division
Exam Works

ExamWorks appreciates the opportunity to be part of the reform process and to work closely with the DWC for positive change. We believe the modifications outlined in the proposed MLFS are generally positive and benefit the majority of the physicians in the CA QME community. ExamWorks supports the DWC's ongoing efforts to drive positive change in our industry. The company looks forward to working collaboratively with the DWC to further enhance the proposal and move important initiatives forward, such as equitable reimbursement for mental health evaluations and other complex cases. ExamWorks continues to support this constructive process.

Seth Hirsch, Ph.D. July 9, 2020
Licensed Psychologist

I am submitting the following protest letter on the proposed medical-legal changes for your consideration. My focus will be on the changes for supplemental reports (from the ML106 hourly rate to $950 flat rate for psych supplemental evaluations to include 50

pages of review, with an additional $3 per page for the next 1,950 pages).

The new proposal will be cost prohibitive for me as well as others. As I write this, I am in the process of completing a supplemental evaluation which has engaged me through this past holiday weekend. There are an estimated 300 pages of medical records to review. As I figure it, I might be able to bill $1850 for this evaluation. At the moment, I have 13 hours of work invested . I still need to develop a discussion. Also there will be proofreading and editing. There will probably be another one and one-half to two hours of work before this supplemental evaluation is sent out. When I subtract out transcription costs and overhead expenses, I will be earning just about $100 an hour. Assuming this to be the norm, carrying out supplemental evaluations becomes more difficult to do, if not, as indicated, cost prohibitive.

Currently, I have a backlog of 35 to 50 supplemental evaluations to be addressed. Due to the press of schedule (evaluations and treating injured workers), getting to them with the new arrangement will be that much more difficult.

The hourly rate is much more reasonable. It probably should be increased. As I understand it, there has not been an increase in many years.

Jo Cinq-Mars, Billings & Collections Manager
Certified Hearing & Lean Representative
Orthopaedic Medical Group of Santa Ana
West Coast Orthopedics
South Coast Orethopedics

July 9, 2020

Upon review of the Proposed Medical-Legal Fee Schedule, we still have many concerns. Although many changes are an improvement, we feel there is still room for improvement. We are in agreement with the changes proposed by CSIMS and COA, of which it is our understanding were agreed upon during the stakeholder meetings, however, we feel there are additional issues which need to be taken into consideration.

- ML200 Missed Appointments

    1. If either the applicant or physician terminates the evaluation prior to completion, this should be added as a criteria. Documentation to be provided.

- A flat fee ML201, is a great starting point with the addition of the review of 200 pages of medical records, however the following problems exist:

1. the additional pages over and above 200 should all be paid at the $3.00 rate. It is does not require less time to review pages over 2000. As a matter of fact, it becomes more complicated and time consuming to record and support documentation contained within voluminous evidence.

2. Parties should serve cover letters and records 15 days prior to the evaluation. Defendants should be responsible for page count, and discs and records should be indexed and in proper chronological order.

3. Evaluations involving multiple injuries and/or multiple body parts become more complicated than the single injury / single body part evaluation. A perfect example of this would include professional athlete evaluations. These evaluations are extremely complicated and time consuming as injuries have been sustained over multiple years and include examination of head to toe body parts / body systems. In addition, apportionment must be broken down throughout the applicant's entire playing career / teams, which in many cases can be traced back to adolescence. The age of these injuries also requires that physicians address both pre and post 2005 rating schedules. Therefore, due to the complexity of evaluations such as this, there should be an additional allowance.

- A flat fee ML202, is also a great starting point, however the following problems exist:

    1. A follow-up / re-evaluation should occur within 9-12 months of the prior evaluation. 2 years after an initial evaluation is too long, a physician could not possibly be expected to remember in detail what occurred during an evaluation that took place 2 years prior. The physician will be required to spend time reviewing his entire prior record, without any reimbursement. This could include voluminous pages of medical records previously reviewed.

    2. the additional pages over and above 200 should all be paid at the $3.00 rate. It is does not require less time to review pages over 2000. As a matter of fact, it becomes more complicated and time consuming to record and support documentation contained within voluminous evidence.

- ML203 Supplemental Evaluation issues:

    1. The time limit for requesting these reports should reflect the same time limit as a follow-up evaluation. Issues are raised which require a response from the QME years after a prior evaluation, however service of additional records are not necessary. Therefore, as the physician is required to re-review all his prior medical reporting to address the requested issues,

there should be an additional allowance for time spent re-reviewing all prior reporting.

2. the additional pages over and above 200 should all be paid at the $3.00 rate. It is does not require less time to review pages over 2000. As a matter of fact, it becomes more complicated and time consuming to record and support documentation contained within voluminous evidence.

- ML206 Remedial Supplemental Medical-Legal Evaluations – we incorporate all points raised by CSIMS:

1. The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this prior to performing the service. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

- -94 AME Modifier

1. AME’s are held to a higher standard in the workers’ comp community and in the courts. The additional allowance of x-1.25 should be added to all services including the review of medical records, subrosa recordings, and medical testimony.

Thank you for your consideration.

Yashar Ilkhchoui, MD, QME July 9, 2020

It is brought to our attention that DWC is completely ignoring Sue Honor 2018 proposal for a new Medical-Legal Fee Schedule. This was a proposal widely endorsed by the QME community.

The reimbursement you are proposing instead is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.
The proposed changes are unacceptable. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

Many of my colleagues have quit serving as a QME. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

John M. Stalberg, M.D., J.D. July 9, 2020

[I have functioned as a forensic psychiatrist for over 40 years, and have been a member of the State Bar of California for nearly 20 years.]

One of the most crucial parts of an evaluation is the **report preparation.** Now, **no fee** is to be paid for the meat of the report containing opinions and supporting reasons. In report preparation –really a creation-- I analyze the record review, along with the notes from examination, the interaction and my perceptions of applicant comparing and contrasting all that with my opinions and legal requirements so as to reach a report of substantial medical evidence.

It would be an injustice to all the parties and not beneficial to the court if I took my notes from the evaluation and attached a record review and submitted that as my work product. Without intertwining my medical opinions for the instant matter with the applicant's affect and presentments, records (including analysis of other physicians' treatment, impressions and findings,) research of topics, if necessary based on what is relevant and particular to each applicant, how could I possibly provide a determination that is accurate, complete and beneficial to all parties in the matter?

Arriving at medical/legal conclusions requires that I utilize my experience inclusive of knowledge of medication, historicals, legal statutes, specific worker's compensation legal precedents and a wide range of case specific intangibles such as an evaluation of behavior not related to just answering questions.

The incorporation of these factors is a component of time spent in preparing the report. It varies from applicant to applicant depending upon various factors such as type of injury, pre-existing matters, complexity of applicant's history, psychological impairment, veracity, requests emanating from the attorneys/judges, etc.

A great deal of time is spent synthesizing and analyzing reports. Psychiatric reports specifically have issues that are **not** in any other field of medicine such as Labor Code Section 3208.3, the *Rolda* case, the *Verga* case, and *Fujimoto* case, in addition to the usual *Benson* analysis of apportionment which is quite often more complicated in psychiatric matters. I cannot simply sandwich together notes from the evaluation with record review and present that to the parties.

Further, as demographics have progressed throughout the years, the days of the 20-year-old applicant with barely any significant history is rare. Contemporary applicants are in their mid-50s with complicated historicals such as several marriages, multiple impacted children and/or grandchildren (all too frequently deceased,) employer, prior workers compensation and legal cases, incarcerations, serious medical problems, medication overlays, etc. - – issues which **orthopedic surgeons can mostly ignore, but that an expert forensic psychiatrist cannot**.

A report is not just simply taking the notes from the examinations, notes from record review, and speedily dictating and sandwiching the two. Legal standards mandate a great deal of time spent in thinking, deliberating, applying medical and psychiatric knowledge and legal opinions in an organized manner, before dictating and issuance of a report that is fair and honest despite any repercussions to either side.

The suggested removal of report preparation time eliminates this essential portion of a substantive report. The current fee proposals do not take this into account. Damage will be caused to applicants, employers and the court process as preparation of the report is the origin of substantive evidence. This does not include time that is spent in evaluation or record review.

It is time spent in cogitation, separate and apart to assess the information provided and generate cohesive correct opinions. Often, it is at the latter part of the evaluation when the applicant is no longer working on giving me their "story," at hour 3 and beyond, when I have established rapport with the applicant. They no longer see me as just another doctor in the pipeline. I have heard their position and if they are malingering, they begin to contradict themselves. I can also observe physical status and their

comfort level with me. Frequently, this is when truths evolve that impact apportionment and outcomes.

However, this cannot be “timed” by the insurer like record review, or length of exam. Each report is signed under penalty of perjury, so the employer and ins. co. seem to not to ‘trust the examiner’s declarations under penalty of perjury.

Report preparation time is a vital component that the insured has no independent way of the time spent doing it. Therefore, they choose to just ignore it to the detriment of the applicant and the court.

When I was in my Fellowship at the USC Institute of Psychiatry and Law, the focus was almost completely on criminal cases-competency to stand trial, insanity, dangerousness and treatment needs. Even a murder/death penalty case has a very modest file—usually just arrest report and transcript of preliminary hearing. The defendants are usually under 30 years old with very little history of significance. So the vast majority of time is spent studying the facts of the criminal case to provide well reasoned opinions.

Often a great deal of time is spent weighing the pros and cons of my opinions—the report prep time. Hence, my strongly held opinion that report prep is by far the most important part of my report to the attorneys and juge.

Regarding the proposed 1.5 psychiatric modifier, psychiatric evaluation should be given much more than a 1.5 modifier. Recall that in the early days of worker’s comp, an initial orthopedic evaluation required just 20 minutes. There is 30 minutes for internal medical. However, the psychiatric exam minimum is 60 minutes.

Therefore, at that time, the state acknowledged that psychiatric took 3x as long as an orthopedic.

As far as re-evaluations are concerned, much can occur between 9 months as it is now and the proposed 24 months. That is not the proper time for re-evaluation. Many more things happen in 24 months -- it is nearly 3x as much time from 9 to 24 and the fee does not reflect that increased volume of possible events. Re-evaluation should be at 12, months, and not 24 months.

Regarding record review, why the decrease in payment from $3 per page be paid up to 2,000 pages and then to $2 per page? I am at loss why-- as the rationale seems to be that automatically the doctor, somehow, is receiving less information, and reading more quickly after 2,000 pages. The fee is arbitrarily reduced to $2 per page.

I assess many, many applicants, 5, 10, , or 20 years after the first visit to my office. Unfortunately, I do not recall them without a review of my complete file. It would be

impossible for me to accurately address any issue regarding an applicant without familiarizing myself with their material and that should be included in the fee schedule.

Under the new proposal, there is no compensation for time spent in reviewing my file in preparation of a supplemental report or for a re-evaluation. If, for instance, I am propounded a complex set of questions, it would be impossible for me to have the knowledge at immediate hand to provide a substantive response without a review. It is unfair to expect thorough knowledge on my part of each file and an innate ability to generate a response without analyzing, cogitating and developing a response to the interrogatory. This proposal directs me to unfairly treat the applicant.

As for the depositions, the wording is unclear. For example, if a **2**-hour deposition is set, then it is untimely cancelled, the doctor should be paid for all his preparation time and his **2** hours set aside for the deposition which he could not otherwise professionally utilize. Also, a deposition is NOT complete until the deponent reads, corrects as needed and signs the depo.

Frequently I receive no records going into an examination because of inefficiency, inability of the parties to agree or whatever the problem may be. In order to cause no harm to the applicant's case, I do proceed with the examination and then do a record review later. If necessary, after review of the records, I may need to re-examine the applicant and that should be allowed.

However, if I have no records, my examination could take 4 to 6 hours. Not compensated for report preparation, no compensation for record review so the evaluation, which takes considerable amount of time, is being unfairly the only issue that is being paid for.

Of course, without records I understand that I have an option to cancel the visit, but I do not like to do it because doing so does not facilitate expeditious resolution of the applicant's claim.

Lastly, why is the -94 modifier for a court appointment [IME, or regular physician] up to the court to decide? It should be at the AME rate or more.

In summary, my two major complaints described above are that the 1.5 psychiatric multiplier is woefully inadequate for the reasons given.

Secondly, report preparation is the most important part of what examiners do in the med- legal arena. This proposal will not compensate for utilization of our knowledge, training and experience.

Robert Fisher MD QME July 9, 2020

I am extremely upset and disappointed with the proposed new QME fee Schedule. This is not at all like the original stakeholder proposal made earlier this year with Sue Honor. These fees are basically lower than those in the state of Nevada. If you expect fair and equitable and reliable reports upon which the injured worker can't get a proper determination of his or her claim that the doctor should be compensated properly for his time and efforts in evaluating the medical records and not having to count the pages nor put them in chronological order in order to make heads or tails out of the problem of this.

Additionally asking the doctor to store all the medical records will only increase his overhead since more space will be data to store these items.

Counting pages of records will only increase the amount of time necessary to produce a proper report. Additionally there will be probably be arguments about the actual number of pages provided to the doctor. Arranging them in chronological order Will also require extra time in order to make a proper determination regarding previous injury, family history and all of these possibly predisposing positions that will affect a portion months. All of this is not adequately reimbursed by the proposed fees that you will propose for review of records.

Furthermore not reimbursing medical research is fraught with problems since the research is necessary to make a proper decision regarding the clients claims regarding the injury and previous history of family problems, social problems, and perhaps previous injuries and other predisposing factors.

It is also unfair that there has been no cost of living increase included in the schedule. There has been no increase in the fees to doctors since 2006.

I urge you to reconsider the original stakeholder free schedule agreement that was made earlier this year because I feel that there will be a sharp decline in the number of doctors continuing to participate in the Worker's Compensation evaluation program. Quality evaluation should be properly reimbursed in order to get quality decisions for the injured worker.

C. Sherin Singleton, Psy.D., QME July 9, 2020

I am writing to respond to the most recent proposed fee schedule for psychiatric QME evaluations. As a psychologist, I am extremely concerned. Psychiatric claims are different than other types of evaluations. They are far more nuanced, and require a far deeper look into the patient's history and present functioning than orthopedic

evaluations. It is quite different looking into a physical injury than an injury of the psyche, which is unable to be viewed on scans or seen in laboratory results. These psychological evaluations typically take hours (not including record review or appropriate research), as we are diving into the full psychosocial and psychiatric history of the applicants, and having to tease apart premorbid psychological factors, and determine the impacts of those prior factors on the present workplace injury. Psychologists, for example, spend a large amount of time in our training growing our expertise in not only interviewing and data collection, but also, in comprehensive psychological testing batteries that other disciplines do not acquire in their doctoral training. These evaluations inherently require far more time to consider and complete , given the interconnectedness between an applicant's developmental and psychological histories and the impact that trauma and workplace injuries have on their current level of functioning. The interconnectedness of these factors also complicates treatment recommendations and opinions as to the expected long-term impact of the injuries called to question.

The proposed fee schedule would sorely limit the evaluator's ability to spend the appropriate amount of time that is often required in these evaluations, as at some point, it is no longer cost effective to do so. Myself, and many of the psychologists I know, perform QME work as supplemental employment, as psychologists are not compensated at equivalent rates to other disciplines in the medical professions. Decrease in the fee schedule will effectively render psychologists having to work out of their own pockets in order to provide high-quality evaluations, or drastically reduce the comprehensive work that is put into these complicated evaluations. That being said, a substantial pay cut will likely lead to a decrease in the availability of psychiatric QMEs, or a decrease in evaluator willingness to travel to remote locations, in order to be available to underserved populations, particularly in light of the fact that other costs (office space, fuel, etc.) are likely to increase over time.

Finally, the proposed 24-month period for reevaluations is simply too long in regard to psychiatric injuries. Some disorders, such as adjustment disorder, inherently resolve themselves with treatment or the causal stimuli, and changes over time can happen much more rapidly in psychiatric improvement than may be the case for other types of injuries. The current 9-month period is far more appropriate, as it applies to psychiatric injuries. Any evaluation beyond that period really requires a new comprehensive evaluation, in order to incorporate the impact of dynamic factors upon the injured worker.

Diane Worley July 9, 2020
California Applicants' Attorneys Association (CAAA)

The California Applicants' Attorneys Association ("CAAA") offers the following comments regarding the proposed revisions to the Medical Legal Fee Schedule which are currently posted on the DWC Forum.

Initially, CAAA thanks the DWC for its' continued efforts at revising the med-legal fee schedule after receiving feedback at a series of stakeholder meetings beginning in the Fall of 2019, and extending through the end of January 2020.

These meetings occurred after two unsuccessful prior proposals to revise the med legal fee schedule were posted on the DWC Forum in May 2018, and August 2019, resulting in an outcry of opposition, and requiring the DWC to go back to the drawing board.

Simply put an update of this schedule is long overdue (last updated in 2006).

However, despite making progress, problems persist in this current proposal posted on the DWC Forum, and therefore, this should not be considered the final step in the process.

With the ongoing attrition in the number of QMEs remaining in the system willing to evaluate injured workers there is an extraordinary lack of focus from the DWC about how complex evaluations require sophisticated, knowledgeable, experienced, evaluators who are paid properly for the work they do.

The DWC complains about poor quality reporting (which is an issue) but fails to have any plan to reward evaluators for doing extraordinary complex work in a timely and thorough fashion. Instead they are prioritizing the "bottom line" for the payors for the most basic medical legal evaluations.

All parties will be negatively impacted by an inadequate fee schedule, although injured workers the most.

Adequate QME/AME compensation is critical to the ability to obtain substantial medical evidence required to prove a claim.

With these issues in mind, the following are our general comments about some of the more problematic proposed revisions presented on the current DWC Forum.

ML 202 provides for payment for a follow up evaluation in the amount of $1316.25 if it occurs within 24 months after the initial evaluation. The current fee schedule defines a follow up evaluation as occurring within 9 months and there is no reason this time period for a follow up evaluation should not continue to be appropriate. 24 months is too long for an evaluation to be considered a "follow up". A lot can happen in an injured workers' case including a significant change in their medical condition and diagnosis in

24 months. This proposal would preclude adequately addressing these changes in an injured workers condition over time due to this lower payment.

ML 206 provides for no payment for a “Remedial” supplemental med legal evaluation. Specifically “This code shall be used for supplemental reports following the physician's review of: (1) information which was available in the physician's office for review or was included in the document record provided to the physician prior to preparing a comprehensive medical-legal report or a follow-up medical-legal report, (2) addressing an issue that was requested by a party to the action to be addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation, or (3) addressing an issue that should have been addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation pursuant to the requirements for a medical-legal evaluation and or report as required by any provision of title eight, California Code of Regulations, sections 9793, 9794 and 9795.” The terms in this new section are extremely vague, difficult to measure, and may be prone to abuse by carriers, who will be allowed to deny payment under this section, without any oversight or semblance of neutrality. Circumstances under which a reduced payment is owed for a supplemental medical legal evaluation should be more narrowly defined and the reduction in payment should only be due for repeat violations by a QME that can be independently documented, not simply determined by the carrier.

ML 201 through 203 modifiers should include record review. It does not seem logical to exempt record review from the AME modifier. It’s usually what’s in those records and gaining a good understanding of them that takes time and makes such a case so difficult and complex to evaluate.

Per page fee should not decrease with increasing page count. This decreases the incentive for a QME to thoroughly review all records and address all questions for a quality report.

Because of the complexity of a psychiatric, toxicology, or oncology evaluation, modifiers –96, -97, -98 should be at a higher level, such as 2x or 3 x, as discussed at the stakeholder meetings.

Lastly, a Cost of Living Adjustment (“COLA”) is needed in these regulations.

The State Auditor’s report expressly recommended a COLA, but this has been ignored by the DWC .

” To ensure that the DWC maintains a sufficient supply of QMEs and appropriately compensates these individuals, the Legislature should amend state law to specify that the DWC review and, if necessary, update the medical-legal fee schedule at least every two years based on inflation. “ -State Auditor(11/2019)

Rather than waiting for the long process of legislation, particularly in these COVID 19 times, a COLA modifier should be built into these regulations, which can easily be linked to the Consumer Price Index for inflation.

Juan C. Larach, MD
Diplomate, American Board of Internal Medicine
Specialist in Clinical Hypertension, ASH
Certification in Geriatrics
Yale Medical Class of '82

July 9, 2020

This is a letter to provide commentary on the currently-proposed medical-legal fee schedule.

The main background issue herein is the lack of cost of living increase for medical-legal evaluators ***over the past nearly 15 years***. [Though I understand that this has not been the main concern in the DWC's production of the currently-proposed medical-legal fee schedule.] The absence of cost of living increase has occurred *despite the DWC being legally required to do so*. The cost of living increase should have been automated but was not. Notably, one of the requirements included that the DWC reviewed the medical-legal fee schedule (MLFS) every time there were modifications to the OMFS, which has occurred frequently, without any concurrent update of the medical-legal fee schedule.

I understand that throughout these years the percent expense for medical-legal evaluating services has remained unchanged, even though the number of cases reviewed by medical-legal evaluators has increased dramatically. Therefore, this is also evidence that, on average, we have been providing services at a very significant discount compared to nearly 15 years ago.

Note that neither the earlier agreed-upon MLFS (with CSIMS) nor the newly-proposed MLFS (breaking away from the earlier-agreed schedule) have made allowance for retroactively making up for the absence (loss) of cost of living increase over the past nearly 15 years.

Over the same time, I have been surprised to recently find out that *salaries* for clinical work within my specialty (Internal Medicine) have *doubled*. This fact significantly changes my perspective on whether I should continue to act as medical-legal QME. At current rates, my time as medical-legal evaluator is substantially undervalued (at about 50%).

Now the DWC proposes to *further* decrease the payments for Internal Medicine services which are very cognitive-intense. The proposed medical-legal fee schedule is not only eliminating cognitive time factors (our professional ***WORK***) but also does not even accord with an earlier agreement with our representing organization, CSIMS. Note

that ***the Division of Workers' Compensation is*** therefore ***devaluing our cognitive WORK***. ***We are also workers***.

The claim that the "complexity" factors within the current fee schedule are "controversial" highlights the fact that both the DWC and the payors do not value the cognitive time, effort, and research required for medical-legal services that my and other specialties provide. Also implicit in the "controversy" is the lack of confidence that we medical-legal evaluators are not being honest about the amount of time we contribute to each report. This is an insult to our professionalism; the DWC knows that within each report we legally swear to the accuracy of our data, conclusions, and billing. I understand that CSIMS has specifically proposed a 2x modifier for reports in Internal Medicine.

The obvious consequence of not paying for the medically-required time spent in analyzing and researching injured workers' cases is quick & shoddy work. Personally, I cannot tolerate shoddy work; that is not what I have been trained to do as a physician. Though I expect that shoddy work would generally favor the insurers, I can also conversely envision situations in which shoddy work might favor the case of the injured worker.

There are more specific problems with the proposed schedule. My representing organization, CSIMS, has presented these to you in detail. I list below the ones that I find most egregiously in error.

The proposed schedule insists that any evaluation performed less than 2 years after the first should be considered a "follow-up evaluation" (to be billed at the potentially much lower fee schedule than the current "follow-up evaluation" fee schedule). This timeframe does not conform with clinical reality. The current less than 9-month span to be considered as a follow- up evaluation has seemed to me over the years to be very reasonable. In my specialty, it is *extremely* common for injured workers to develop a new Internal Medicine complication/injury 9-24 months after the first evaluation. Examples are legion; if requested, I will gladly provide the parties with examples.

The DWC wants to pay for reports in part based on number of pages to be reviewed. Personally, I find this to also be a ludicrous idea, given that currently-received boxes of records contain many pages with little or no information. Conversely, many of these pages are very information-dense and may require significant time to review & analyze in context with other data. Be that as it may, if the DWC is to use the number of pages to be reviewed as a criterion for payment of services, then: 1) font needs to be specified, 2) spacing needs to be specified, 3) size of page needs to be specified, 4) to avoid future conflicts, cover letters need to state the number of pages being forwarded.

Furthermore, there is no logical reason for decreasing the payment from the proposed $3 of page to the proposed $2 of page after a certain number of pages. We are not an automated factory that can produce larger volumes at a discount

The proposed fee schedule insists that any medical records received before production

of the report should be incorporated within the report. Late receipt of medical records is a common phenomenon. It is impossible to incorporate within a near-finalized report, at the last minute, information from medical records received within the last few days. Note that the current fee schedule does not allow for a Supplemental report for records received immediately before or after creation of the report.

In conclusion, though the currently-proposed fee schedule would significantly benefit evaluators that provide short, straightforward, less brain-challenged work, that is not the case for many of us. Based on the currently-proposed fee schedule, the quality of my cognitive work as Internal Medicine specialist would be recognized and more appreciated elsewhere.

Furthermore, restructuring of my medical-legal office time would require slimming down the number of my supporting employees.

Christopher Simonet July 9, 2020

After further consideration of my previous response, I wish to clarify that I believe that a 3.0 multiplier for psychological and psychiatric evaluations is warranted. Mental health providers are the clear losers in this proposal. Mental health evaluations are undeniably more complex (on average) than other evaluations and even the current billing code acknowledges this by providing a complexity factor for psychological and psychiatric evaluations. The multiplier of 3.0 is already implicitly present in the current code as the regulations state that examinations for psychological and psychiatric evaluations must be a minimum of one hour--vs. 1/3 hour (20 minutes) for other specialties. I currently do my QME evaluation as efficiently as I believe possible without reducing the quality of the reports I submit. The current proposal will make thoughtful, reasoned, yet efficient work unprofitable for psychologists and psychiatrists. I believe DWC will be left with fewer mental health providers and mainly those providing low quality reports if the proposed schedule is implemented as is. I would predict that the proposed regulations would result in both a net reduction in the quality of evaluations (harming injured workers) and a paradoxical increase in net evaluation expenses in the long run due to the need to re-evaluate and litigate more often.

Saule Buzaite PhD, QME July 9, 2020

I have had time to reflect on comments provided to the DWC Forums RE: Med-Legal-Fee Schedule.

There seems to be two proposals.

First, and Certainly both Sue Honor's (Esq) proposal and the CSIMS' proposal are against the newly proposed Med-Legal-Fee Schedule.

However, I find the CSIMS proposal ambiguous. Sue Honor's (Esq) proposal is spelled out clearly, with minor exceptions.

To All Providers : Please obtain the most accurate information before choosing which proposal is most acceptable.

Gregory J. Firman, MD, JD, QME July 9, 2020

First: I previously objected to the design, per se, of the entire MLFS, both in the current and proposed versions. Physician reimbursement, at least for nonsurgical specialists, should be on an hourly basis, since time and complexity are usually proportional. The current proposals and counterproposals are, severally: demeaning; unnecessarily complex; and nit-picky. Regarding the demeaning charge, I understand that lawyers work on a billable hour basis, with the underlying rationale that they are giving their whole attention to the matter at hand: whether this be drafting a short letter or conducting complex litigation. Physicians and psychologists, the Rodney Dangerfields of medicine, deserve at least some respect.

However, based on peer feedback, I doubt that the above proposal will get any traction, at least at this late stage.

So, assuming that the current model goes forward:

I've talked with others in the field, and the consensus is that the DWC draft proposals will benefit all specialties *except* psychiatrists and psychologists. If the flat fee for an initial report is implemented, and assuming that there will be no major changes in report requirements, that fee simply should be higher, at least compared to my own prior charges for an ML 104 report (and, more objectively, if compared to ML 104 charges for psychiatry/psychology reports in a pooled cohort).

Finally, the conversion factors for all dollar amounts in the MLFS should be indexed for inflation.

Thanks to all parties who have been actively involved in this long-overdue process.

Theresa Cokley, Regulatory Compliance Specialist July 9, 2020
CorVel Corporation

We have the following questions/ comments/ input /concerns.

*Will there be a code set up for the record review charges?

-Since 99358 / 99359 is based on time and a different value, it would be in the best interest from a coding perspective to set up a code for ML per page rate(s) – it would reduce the amount of manual calculation errors, and physician fee schedule reimbursement override. (Example ML207: Record Review w/ the per page rate)

*what happens when the f/u doesn't happen w/i the 24 month period?

Sometimes there are multiple follow-ups spanning over years. What does the code become if they have a f/u that is over 2 years from the initial? Is it then an initial again?

*I do not see anything in the regulation confirming that PPO discounts are not applicable. Are PPO / Contract discounts applicable?

*Just to confirm, where records are paid at the per page rate, there is no charge or allowance where there are gaps

For example: ML201 says up to 200 pages included, 201-1899 =$3.00 per page | 1900-2000 nothing is mentioned | 2K and up is 2.00 per page : So if a provider reviews 1900-2000 pages we don't pay them (it says up to 1800 is 3.00 and no pages are addressed until the 2k page mark at 2.00 per page)

Katya Cornejo, PsyD, QME July 9, 2020
Clinical Psychologist

I am writing this letter because as a psychologist and Qualified Medical evaluator, I will be significantly adversely impact by the DWC's proposed changes to the current fee scheduled. Mental health evaluators perform very complex evaluations and take a great deal of time to complete. Our evaluations require a minimum of 60 minutes in duration and the proposed changes will uniquely hurt psychological evaluators. This situation will likely result in a decrease of psychological evaluators, we cannot afford to continue to do our work with the proposed fee schedule and this will ultimately negatively impacting injured workers.

What is clear is that the current proposal has an imbalance and favors certain specialties while negatively impacting. Honestly, as a professional, I will have to make significant cut-backs to the QME work that I do if the changes to the fee schedule are implemented. There is no way that I can maintain my practice and financially support myself with the proposed changes. Therefore, I will need to cut back on the number of

evaluations I perform. I also want to point out that It would make the most sense for a fee schedule to include an automatic annual cost of living adjustment so that we, as evaluators can continue to earn what is necessary to keep our practices going. Medical legal evaluators have not received a cost of living adjustment in 15 years. This is not in line with any other professional form of work and is not right.

I do not believe that fairly compensating mental health evaluators as we are requesting will place a financial strain on the current budget. This is based on the percentage of mental health QME panel requests, which is about 10%.

I am asking for a minimum of a three times modifier to all psychiatric and psychological reporting and this is based on the lengthy examination and report writing time that is required of us. I am also requesting that a $3.00 per page fee for medical record reviews be allowed regardless of type of report. The work involved in reviewing records does not change based on type of report and therefore the fee should not as well. Additionally, as noted above the fee schedule should include an automatic annual cost-of-living adjustment in line with other professional work. In terms of reevaluation billing, it is important that a reevaluation is defined as an exam requested within 11 months of the prior exam and were the applicant is available for a reevaluation within 60 days after the request. If these conditions are not met than it is important that a new evaluation be able to be billed at the initial rate. I additionally want to point out that the way that an unreimbursed “remedial supplemental evaluation" is defined is completely unacceptable and does not view our work fairly or provide for just reimbursement.

Thank you for your time and I trust that you will take my opinions into consideration when making these important decisions for our profession.

Joseph Moza, MC, FACS July 9, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,800 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all

stakeholders.

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The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

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This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Ann Richmond, Pesident July 9, 2020
Work Comp Medical Services

I have a medical billing company and have been in business doing soley California medical billing for QMEs and treaters since 1994. I help about 40 QMEs in the State with billing and scheduling. I have reviewed the proposed new medical legal fee schedule and have the following comments:

1. A **giant issue** is that you have proposed a code for each type of QME report and modifiers for some. Within the description of those you explain that any records beyond 200 pages can be also billed at a certain rate up to a certain amount, **BUT YOU GIVE NO BILLING CODE OR RVU FOR THIS SERVICE**. I see this as major issue. The code for the exam is a flat fee. There must be a code for review of records pgs 201-2000 and yet another code for records beyond 2000 pages since that is a different rate.
2. Now I will say that I understand the DWC met with Stakeholders on both sides, providers and payers, and that certain agreements were made at those meetings. Why would the DWC go against what payers agreed to with providers in these meetings? Does someone at the DWC have deep pockets? It feels that

way. It is my understanding that the DWC has neglected these agreements and is proposing lower per page record review, lower psych multiplier, longer time for reevaluations, the agreement that medical records are required to be received 15 days prior to the appointment. **It really feels like the DWC is punitive to doctors and I hear rumblings of doctors wanting to get out of work comp because of this climate. I had at least 6 QME's leave work comp due to DWC underground regulations. If psych multiplier does not increase above 1.5 I know several QMEs that will be exiting.**

3. This may seem minor, but if not corrected will wreak havoc. That is that it is ok to send 8.5 x 14 paper for records. There should be a premium for this size paper as it will be very difficult for small providers to deal with legal paper. **NO 8.5 X 14!**
4. Reevaluation time period of 24 months is way too long. It should be no more than 12 months.
5. This hasn't changed but has always been unfair. Doctors are required to produce a complex narrative report within 30 days but payment is not required before 60 days. Even when records are delivered late. I don't get that. It's just a favor to the insurance industry.
6. The new regulations also still do not allow providers to file Petition for Benefits and call for a hearing when the carrier unjustly does not pay for QME reports.

Linda Cocchiarella MD, MSC July 9, 2020

As a QME, CSIMS Member and editor of the AMA Guides 5th edition, I am writing to express my deep concerns about the proposed QME fee schedule and its potentially detrimental effects on the Ca workers compensation system.

The proposed changes, with higher reimbursement for basic evaluations but lower reimbursement for more complex evaluations, will not have the desired results of improving the quality of medical reports, improving the health care of injured workers or their satisfaction, or bringing quality QMEs into the system. It also is unlikely to decrease costs. The proposed changes if enacted will likely lead to the reverse. If the DWC violated the stakeholder agreements in order to favor the insurance carriers, which is how it appears, this will not favor the carriers as planned.

The reimbursement, although higher for very basic evaluations, will likely lead to an increased number of chiropractors doing evaluations and perhaps some orthopedists. Chiropractor expertise, from my experience, is not oriented to address causation, work restriction and return to work issues.

Apportionment allocation will decline in frequency and amount since the time needed to take a detailed history, and do adequate research, will not be adequately reimbursed for. Therefore, QMEs will not be able to probe about other health conditions which lead to impairment, with resulting higher ratings. Fewer requests will be made for primary care or pre injury medical records to address apportionment, as there is insufficient reimbursement for a supplemental report; pre injury medical records to fully address apportionment are rarely given at the time of the initial assessment. These evaluations are not like a treatment assessment which can be done more quickly. Sharing their story and seeing this reflected in their medical evaluation, has contributed to healing in some claimants. A detailed history will not be possible in many instances, given the proposed reimbursement.

More histories will likely be taken by non physician historians ,since QMEs will reserve their time for a focused evaluation, analysis and review; with key details missed. The claimant will have even less time will be spent with the evaluator, another source of dissatisfaction. Important details not collected initially may lead to more depositions with the less satisfied party trying to prove an inadequate evaluation and requesting another QME. Rebuttal of presumption will be unlikely without the time needed to research the literature for the latest findings. Especially in the fields of internal, occupational medicine and causation, research is critical. If the parties wanted to disallow research, they should have specified no research older than 5 years will be reimbursed to ensure the latest findings are included. Higher costs, a less accurate evaluation, and a more dissatisfied claimant will likely result. Furthermore, it is not likely that the resulting medical reports will meet the test of scientific evidence since evaluators will not have the time to ensure the latest scientific research is included.

I have done a limited comparison of prior and proposed reimbursement for internal medicine cases. Based upon a limited review, the income lost for some complex internal medicine cases would be at least 20%. Decreases in apportionment will lead to higher settlements.

If the parties wanted to improve the quality of medical reports, they should have honored the terms that were agreed upon in the QME stakeholder process. I agree with the CSIMS recommendations I have listed below:

	DWC Stakeholder Meetings	**California DWC Proposal**
Reimbursement per page	$3 (starting on page 201)	$3.00 (pages 201 – 2000) **$2.00 (pages 2001+)**

	DWC Stakeholder Meetings	**California DWC Proposal**
Definition of page	8 ½ x 11”	8 ½ x 11” OR **8 ½ x 14”**
Definition of re-evaluation	9 or 12 months	**24 months**
AME Modifier	1.25x and applies to **all services**	1.35x but applies **only to flat fee and not to depositions**
Medical records required to be sent 15 days prior to evaluation	Yes	**No**
Cover letter required to specify number of pages sent to doctor?	Yes	**No**
Automatic Annual COLA Increase?	DWC refused to hear this issue in the stakeholder meetings	**No**

DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page, because this was agreed to.
- Pages should not be legal sized, only standard sized, this seems ridiculous to even have to say.
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months. Things change substantially in 24 months- although I would find 15 months acceptable personally.
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation

- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI for Medical Care in California.
- The definition of missed appointment is too narrow and should be expanded to allow for: the injured worker leave prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i).
- The cut-off date for QMEs to include records or sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report.
- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.
- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.
- Neurology and Internal Medicine evaluations should be entitled to 2.0x modifier.

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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Shereen Tabibian PsyD, QME July 9, 2020

Psych interviews are more complicated and require at least two to three hours. The time to write these reports is also extensive. A psych report requires a comprehensive history gathering of the injured worker and their family, per the DWC guidelines. It often requires a description of continuous trauma including numerous specific events. The

report also frequently requires a Rolda analysis. A modifier of 1.5 is unacceptable and should be 3.0, which is more in line with the time required.

It makes no logical sense that records 1801 and beyond will take less time to review than the first 1800 pages. There should be a flat fee for all pages of $3.25 for all pages reviewed, which is consistent with the proposed new hourly rate of $325 an hour. There also needs to be clear stipulation that double sided pages count as two pages, condensed depositions count as 4 pages, and a standard page size is 8.5x11.

There must be a more adequate deadline regarding receipt of records. If a doctor has plans to complete the report on the 27th day and mail, but on the 26th day receives 1000 additional pages of records, it would be impossible to review and include these records in the report. The proposed time frame is flawed because of this. A reasonable cut off date would be the date of the evaluation.

A period of 24 months is too long to be considered a re-evaluation. The amount of records and interim information can be extensive and the re-evaluation rate is inadequate for this. The span should be no more than 12 months.

The DWC must add an automatic annual fee increase so that QMEs are not without a raise for several years as has occurred since the last fee schedule change. A fee schedule that does not include this will be incomplete.

Jason Schmelzer July 9, 2020
California Coalition on Workers' Compensation

I write on behalf of the California Coalition on Workers' Compensation (CCWC) regarding the proposed amendments to the Medical-Legal Fee Schedule. We'd like to thank you for the ongoing efforts to develop a reasonable fee schedule. The current forum proposal largely aligns with stakeholder meeting discussions but continues to raise concerns that need to be addressed in a number of areas. Many of the recommendations adopted by the stakeholders in attendance were not unanimous and the stakeholders represented only a small body of folks. Therefore, while there are some differences between the proposed regulation and what was discussed in the stakeholder meeting, the DWC has consistently made it clear during these discussions that any agreements reached by the attendees were recommendations only that could be accepted, rejected or modified by the DWC.

The California Coalition on Workers' Compensation (CCWC) is an association of California's public and private sector employers that advocates for a balanced

workers' compensation system that provides injured workers with fair benefits, while keeping costs low for employers. Our members include not only businesses of every size, but also cities, counties, schools and other public entities.

Quality and Timeliness of Reports

During stakeholder meetings, a recurring theme was raised by several participants, including payers and providers, which was the need to address quality and timeliness of QME reports. The current proposal addresses neither. There must be some mechanism to address these key components. Paying higher rates for the same quality is not acceptable and does not address the issues raised during the stakeholder meetings

ML Code Reimbursement Levels

The levels of reimbursement provided by the current draft are appropriate and align for the most part with what was discussed and agreed to during the stakeholder meetings. The Nevada based fee schedule proposed by Sue Honor was discussed during the meeting and was rejected as not appropriate for the California system. Its level of reimbursement would significantly increase costs within what is already one of the highest cost systems in the nation and adversely affect employers due to the high inflationary costs it would impose.

Record Reviews

The current level of reimbursement provided is aligned with what was discussed in the stakeholder meetings. The price of the report and record review was designed to provide compensation for all reviews and administrative services associated with those reviews. This helps simplify the billing and bill payment process and will also help reduce billing disputes. In theory, the goal was to appropriately compensate QMEs for review of relevant records while reducing the risk of abuse within the system. Under the current proposal, there is still no mechanism to address potential abuse or situations in which a party submits records that are duplicative or irrelevant to the issues. This can lead to excessive submission of records and artificially inflate the volume of records the QME is required to review. Notably, during the meetings, the providers were in favor of processes that would help clean up the records before they received them so that they could focus on the relevant records. To accomplish these aspirations, there need to be controls that help mitigate risk of abuse, provide QMEs with a good record set and manage costs, especially in situations in which voluminous records are submitted. Otherwise, there remains a potential for increased abuse and significant increases in the amount paid for review of records. While payers can and should address the relevance of the records submitted by the payer, the payer has no control over what is

submitted by the opposing party. Possible alternatives that can be considered to address these issues include:

1. Modify the fee schedule to limit submission of records to those that are relevant to the issues and include a provision or penalty to address abuse. The requirement that QMEs review only records relevant to the issues being presented is established and supported by Labor Code §4062.3(2) and 8 CCR §41(c)(2). However, there is currently no mechanism to enforce relevancy. Building relevancy into the fee schedule will provide parties a method to contest the relevancy of records submitted by the opposing party prior to the QME review. This allows a party, at their discretion, to take measures to ensure only relevant records are submitted to the QME for review. If the party does not object or seek to limit relevancy, then they assume the risk and pay based on the fee schedule. Such a process could help reduce the record review burden placed on QMEs and help manage the cost of reviews in which voluminous records are involved.

2. Create a definition of relevant records that excludes records known to not be relevant, such as administrative and billing/payment records.

3. Establish a cap on the number of pages for which reimbursement will be provided.

4. Base payment on the largest set of records submitted by either party to mitigate the risk of paying for duplicative records or pay based on the common number of pages submitted and a lesser amount for the differential between the two sets of records submitted.

5. Require a meet and confer when records submissions exceed a certain volume to reach agreement on relevancy and records for submission prior to submission to the QME for review.

Modifiers for Psychiatrist, Psychologist, Toxicology and Oncology

The modifiers for these specialties are appropriate but need to be tied to the ***legislative*** requirement for "***extraordinary circumstances***" pursuant to Labor Code §5307.5. This can be done through the development of an appropriate definition of "**extraordinary circumstances**." During the stakeholder meeting, these specialties were supported for application of a modifier due to not only the fact that these were extraordinary evaluations that required analysis of current scientific studies against the medical record

in order to address issues presented, but also the difficulty in locating specialists to perform the appropriate reviews.

We therefore recommend that the DWC include a definition of Extraordinary Evaluation to be any evaluation performed by a psychiatrist, psychologist, toxicologist or oncologist, only.

Per the Workers' Compensation Insurance Rating Bureau (WCIRB), in calendar year 2019, $290 million was spent on medical-legal evaluations **[Report was submitted with comments and is available upon request.]**. That was an increase of $10 million from 2018 calendar year. This number reflects only payments made by insurers and not self-insured employers. While we have consistently supported increases to physicians who perform evaluations, we have not supported an environment in which business models can flourish to carve profit centers out of this process without regard to the quality of reports or to costs that have no bearing on the report of the evaluator, the needs of the injured worker, or the resolution of disputes.

Mark Wolkenhauer, PsyD, QME July 9, 2020

Psychiatric and psychological QME evaluations are more complex and take more time than other evaluations. The current proposal specifically adversely effects psychiatrists and psychologists. I agree with the CSIMS in their response to the current proposal. The agreements made in the stakeholder meeting were not followed.

I typically take 3-4 hours to perform my examination. In addition, I rarely bill for all the hours it takes to complete my full evaluation because of the inordinate amount of time it takes to order, review, and analyze the records to come to a conclusion about the psychiatric factors in the case. When I ask colleagues about psychological QMEs they almost universally have the same response: "They are a lot of work for the money." Many colleagues who perform excellent forensic work in other areas have dropped off the panel or limit their work because of the disproportionate amount of work compared to the pay.

The current proposed changes by the DWC would force me and many colleagues I know to either A.) consider dropping off the panel or B.) perform a much shorter and less complex analysis of the case. Neither of these solutions would benefit the injured worker or honor the goal of the DWC in reaching fair settlements in complex cases.

Please consider the CSIMS response to the current proposal. The biggest issue is a minimum 3x modifier being applied to all psychiatric and psychological reporting including initials, re-evaluations, and supplementals.

Tom Pattison July 9, 2020

I have been an QME for about 25 years and I think adopting the new fee schedule is generally a good idea. It is brave to look outside of California go to a new system such as Nevada. Our current system does not really work that well as apparently there are some people that take advantage of it and looking to neighboring states makes sense. However, the DWC should keep to the agreement hammered out between various stakeholders so that this can quickly go through.

My concern would be that the two sets of med-legal fees should be adjusted to the higher one being for when a permanent and stationary report is issued. The lower one could be for any initial and/or subsequent evaluation. This would i**incenitivize** the case moving forward. Frankly, there are always a couple missing records or other reasons to delay the final report, I am afraid the proposed system makes more delays in the system.

Another idea would be to formalize the telehealth system with a fee of about half of the lower fee that could be used to move the case along and would be very helpful for about 20% of the people that I see that are out of state or a travel six hours or more round-trip to see me. These could be converted to an in person appointment after the telehealth visit at using the other fee schedules if necessary. The Ex parte rules would have to be modified.

The major delay that I run into more than 50% of the time is that the recent records are not available. There are usually six months. out of date. They also arrive a couple days before or a couple days after or even a couple months after the scheduled appointment. Thus, extending the time for the report by the number of days that the records are late after the date of the visit would again put incentives in the right direction. While I think there is good justification for a no-charge supplemental report when the QME does not cover basic items, there should be some mechanism of appealing this. Perhaps the bill review system could be used.

For the last 25 years in Sacramento, the problem I see with injury-to-the- psyche claim revolves around the treatment issues. I certainly have seen some incredibly well done and frankly incredibly expensive psych reports, but there is very limited treatment available. That is true for a number of other specialties. Allocating more resources to the treatment end of the spectrum, particularly for underserved specialties, is highly recommended. I would urge the DWC to be flexible and using modifiers so that underserved specialties are incentived to join. Currently, it’s my understanding there are no infectious disease specialist in the system. That’s the DWC should increase modifiers for that specialty to attract people and then adjust them accordingly to keep

enough doctors in the system. This logic should apply to all the various panels With panels that are fully subscribed to not necessarily deserving a increase the multiplier.

The no-show idea with an option of also billing for the record review is a very good change. I am okay with AME modifier only applicable to the visits.

Muriel Yanez, Psy.D., QME July 8, 2020

I am a relatively new psychology QME that now finds myself reconsidering whether I would be able to continue as QME if the proposed fee schedule is adopted. The amount of time required to complete psych records review, interviews, and report would not be commensurate or even remotely fairly compensated by the proposed fee schedule. The fee schedule fails to consider several unique aspects of a psych evaluation that make it a more time consuming and lengthy process and set it apart from other specialty evaluations.

Psych QME interviews and reports will not be adequately compensated by a 1.5 modifier. The modifier needs to be at least 3.0. Psych is the only specialty that has a causation threshold of predominance. In practice this translates into much more extensive, detailed, and lengthy discussion regarding causation and apportionment. In order to attain the needed information to be comprehensive and adequately address the issues, the psych interviews usually take longer than three hours. The psych modifier should apply not only to the base rate but also to record review as the amount and content of the records is frequently much more than for other specialties. The records often include past psychiatric records, personnel records and other documentation regarding social history or background that may not be relevant to another specialty for review but for psych is. The regulations even hold psych QMEs to a higher level of record review than other specialists, requiring us to review records personally, which further warrants the modifier being applied to record review as well as the base rate.

Regarding records review, the fee schedule is frankly illogical. Why is there a drop to $2.00 at page 1801? Is it that records 1801 and beyond will somehow take less time to review than the first 1800 pages? Do pages 1801 and beyond become easier to read, digest and analyze? This is why it is not a logical proposal. There should be a flat fee for all pages of $3.25 for all pages reviewed. There also needs to be clarity regarding ways in which pages may be counted as one when in fact the content would be a review of more than one page. For example, stipulate that double-sided pages count as two pages, condensed depositions count as 4 pages, and a standard page size is 8.5x11.

There must be a more adequate and reasonable deadline regarding receipt of records. It is not reasonable, feasible or fair to have a completed report ready to be mailed on day 26 and then receive several hundred additional pages. In order to review the additional records, it would take time to see how these may or may not impact the conclusions already reached. Ultimately, to not make a thoughtful review of these additional records is unfair to the injured worker. The latest deadline to receive records should be the day of the evaluation. Anything submitted beyond that should be considered a supplemental report.

In terms of psych, a period of 24 months is too long to be considered a re-evaluation and the re-evaluation rate is inadequate given the amount of records and information which can be extensive. The span should be no more than 12 months.

Finally, it is my understanding that some of the reason that there is a need for a fee schedule change is the lack of an annual cost of living adjustment (COLA) in the current fee schedule, leading to QMEs not receiving a pay increase for years. Any new fee schedule should have an automatic annual fee adjustment to keep rates current. Keeping rates current retains qualified, dedicated specialists in psych that can find it cost effective to continue as QMEs.

Susan Marusak MD, QME July 8, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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Andrea Lackovic, PsyD, QME July 8, 2020

As A QME who is truly vested in providing the most salient and accurate evaluations and works very hard to self educated and do so- the proposed changes are very concerning to me as if they were to take place- it would no longer be futile for myself to continue the evaluations or within your proposed structure complete on accurately and fully. My points as synthesized are below

A: A modifier of 1.5 is NOT adequate to pay a QME in psychology or psychiatry. The modifier should be 3.0. The psychological interview alone requires a gathering of extensive information teasing out for accuracies far greater than any other specialty. These interviews often take longer than three hours are very in depth and take a considerable amount of time to do them fully. The information must then be incorporated in a comprehensive report and a lengthy analysis and discussion of how each of these factors does or does not play a role in causation and apportionment. Psych is the only specialty that has a causation threshold of predominance. This requires a much more extensive and detailed discussion for both causation. Psychological reports also frequently require a lengthy discussion of personnel actions and a Rolda analysis, which takes further time and analytics.

B:Why would the doctor be paid $3 a page for records up to 1800 and $2 per page after that? These records will not take less time to review. If the concern is payers sending irrelevant or blank pages for review then the payers should go through and only submit relevant records. The doctor who is sent 2000 pages of relevant records should not be expected to perform this at a lower rate of $200 an hour just because the payers will not screen the records.

C:Doctors need to receive records way before the evaluation in order to perform a comprehensive history gathering and have the ability to read ahead of time. At the very least the cut off should be the day of the evaluation. If we are required to include records received at any time prior to issuing of the report, this is bound to cause delays in reporting and even late reports, which will just complicate the system, causing delays, denied reports, and requests for new panels.

D**:**A period of 24 months is too long to be considered a re-evaluation. The amount of records and interim information can be extensive and the re-evaluation rate is inadequate for this. The span should be no more than 12 months.

E There must be a COLA included with the fee schedule so that the rate that QMEs are paid does not rapidly become inadequate, bringing us back to the problems that is occurring now.

I Implore you take my considerations (which also happen to be those of my peers as well) to heart for the most accurate, salient evals that we complete and not allow changes that allow those who are vested and skilled to no longer perform the evals because of futility and cost reimbursement as this would leave you with those who do not truly have an interest in accurate reports.

Alexandra Clarfield, PhD QME July 8, 2020

I am a psychologist QME writing in the hope of conveying my distress regarding the proposed Medical Legal Fee Schedule. I have been writing such comments twice yearly for the past several years along with numerous other QME doctors. I am weary of commenting on the strategy points involved, although they are obviously important. I chose the field I am in out of a deep commitment to helping other people and I have spent much of my life underpaid and overworked in that regard. In the recent webinars with CSIMS there is speculation as to why a fee schedule change is proposed to begin with. We have not had a raise including COLA since 2006, despite the recommendation from the recent RAND study, and QME doctor numbers are diminishing and the number of claims skyrocketing. Despite the story propounded in the media and by the DWC that we are “abusing the system,” our costs and percentage of the budget remain the same as they did more than ten years ago, while California has become very friendly to the Workers Compensation Insurance Companies that flourish along with their CEOs and administrators, who of course earn many times more than myself and my colleagues. This makes it apparent that collectively we are doing more than twice the work we did in the recent past, for the same compensation. I call “***alternative facts***” on the allegation of abuse.

I remain committed to providing quality services for injured workers. Many times the patients I see feel frightened and alone when they arrive, and typically I am told after, that they found our meeting helpful, that they feel they were heard perhaps for the first time, and that they have some hope about their situation. My reports have been praised by attorneys on both sides for their clarity and incisiveness, for not wasting words going into areas not critical for a decision. I take seriously my commitment to provide objective medical evidence that is fair and humane. And I find offensive the suggestion that the DWC feels the need to protect the insurance companies from us. But perhaps I/we are mistaken in this regard.

That said, a psychological report with sufficient analysis to stand as medical evidence in a court of law is a challenging and demanding task requiring considerable investment of time spent thinking and writing. I know that I do not even bill for all of the time invested and the QMEs with whom I'm affiliated would likely say the same. Despite that, my billing for psychological testing required by the DWC and relevant in the cases I see, even only for 2-3 hours, is nearly always denied when I submit my bills, resulting in my loss (1) cost of my time and the cost of purchasing/scoring/interpretation of tests) or (2) further time spent resubmitting my bills. I cannot imagine that a cut in pay is going to do anything to improve the quality of services provided to the injured workers. The proposed fee schedule is riddled with ambiguity, flaws and aspects that will result in unfairness.

- I note the rate of pay for a re-evaluation is almost half of an initial evaluation although the report is no less demanding in the case of a final psychological evaluation. In fact, it is often more involved due to the need to integrate material of a psychological and/or medical nature that has fluctuated in the interim and to reconsider and adjust final opinions.

- It seems as well that the burden of counting potentially thousands of pages of medical records will fall to me and I can only imagine the resulting nightmare and cost to myself trying to get paid as a result. I am now to go back and forth with adjustors arguing about how many pages were sent ? Even now, they send sometimes thousands of duplicate pages for which I do not bill although it takes time to sift through these and determine what may already have been reviewed. And often records are sent to the wrong address entirely.

- I note as well the "bulk discount" offered to the insurance companies for records over 2000 pages, whereas a case with more records is typically more, not less complex. Again, when I provide a report, if there are thousands of pages of medical records not entirely relevant to my arguments, my billing reflects my time spent, not an exaggeration based on the number of pages. Why not trust doctors to account for our work in real time.

- Also problematic, the proposed flat rate includes review of several hundred pages of medical records which potentially amounts to several hours of work resulting in a poor rate of pay overall in the case of a psychological evaluation.

- I remain concerned as well that the per page system will create incentive for insurance companies to limit the quantity of records provided to save money, resulting in incomplete evidence which already can be an issue that complicates our work.

- Among many things the proposed MLFS will also make it impossible for me to meet legal standards if I am legally required to provide a full report when records may arrive on the last day of a reporting period. My reports are rarely late although I did cut part of my finger off recently requiring stitches and a tetanus shot. I got behind but am still within the emergency regulation provisions, two of my reports went out after about 35 days instead of the usual within 30. Most unfair to require that I include in my analysis a review of records provided at the end of the report writing period. Many times adjustors send records to the wrong address and they are not even received before the evaluation.

- If it becomes impossible to do a good job, or to be compensated fairly and without ongoing conflict with the insurance companies, it will be extraordinarily punishing to do this work and more QMEs will leave. Not all of us are large groups and companies with paid staff, we are just doctors trying to do good work. *Help us and we can help the injured workers whose lives also matter.*

- I hope you will take time reviewing the many other problematic points of the proposed schedule as provided by CSIMS. The MLFS as proposed burdens doctors and does little to support us in providing good work. I would be remiss not to point out that Sue Honor's proposed schedule has never been considered, whereas the points of the proposed schedule can be traced directly to the insurance companies from which they originate.

Michael Amster MD July 8, 2020
Interventional Pain Specialist
NorthBay Center for Pain Management

I am a QME and the current Vice President of CSIMS. I participated in the stakeholder meetings hosted by DWC in January. I found the meetings to very productive and the outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. Unfortunately (but not surprisingly given DWC's

demonstrated track record of bias towards insurance company interests and against injured workers and medical providers), DWC violated the stakeholder agreements in order to favor the insurance carriers. It is shocking and DESPICABLE that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

I am EXTREMELY concerned that the DWC is not providing QMEs an automatic annual COLA increase. There has been no raise for QMEs in the last 14 years, yet our office expenses (rent, staff salaries, supplies, etc) annually increase approximately 3% per year. The DWC provides an automatic annual COLA increase for all other areas of the system, such as copy service and interpreter fees, so why are QMEs excluded from this? The heart of the current controversy on the fee schedule is that DWC has not increased fees for QMEs in 14 years. We have consistently urged DWC to include an automatic annual COLA increase to the fee schedule, but they have refused. This glaring omission guarantees that the QME fee schedule will remain an ongoing issue for years to come. It is UNACCEPTABLE for the DWC to not build in automatic annual COLA increases for QMEs.

DWC should modify the fee schedule in the following specific ways:

- The fee schedule MUST include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California. All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee.
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation
- Cover letters must be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages. The doctor should not be forced to count pages!
- The mental health modifier should be increased to 3.0x
- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)

- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report
- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.
- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.
- Neurology, Pain Medicine, and Internal Medicine evaluations should be entitled to a 2.0x modifier
- Increase the compensation for complex cases with some modifier defined as three or more body parts OR two or more dates of injury
- Supplemental reports should be reimbursed on time spent. I have had supplemental reports that are a 6 page letter from the attorney with 15 questions to answer. This current schedule does not adequately reimburse the QME for their time.

If the DWC is not going to create an equitable proposal from the agreements at the stakeholder meeting, then you should scrap this whole process and replace this proposal with Sue Honor’s proposal which the QME community has already broadly supported.

Lawrence Weil, M.D. July 8, 2020
IPM Medical Group Inc.

As a physician and stakeholder in the QME process, I had thought agreement had been reached between stakeholders on all sides.

The proposed rules however do not appear consistent with what was agreed to. Specifically, DWC made the following changes after agreement had already been reached at the DWC stakeholder meeting:

	DWC Stakeholder Meetings	**California DWC Proposal**
Reimbursement per page	$3 (starting on page 201)	$3.00 (pages 201 – 2000) **$2.00 (pages 2001+)**
Definition of page	8 ½ x 11”	8 ½ x 11” OR **8 ½ x 14”**
Definition of re-evaluation	9 or 12 months	**24 months**
AME Modifier	1.25x and applies to **all services**	1.35x but applies **only to flat fee and not to depositions**
Medical records required to be sent 15 days prior to evaluation	Yes	**No**
Cover letter required to specify number of pages sent to doctor?	Yes	**No**
Automatic Annual COLA Increase?	DWC refused to hear this issue in the stakeholder meetings	**No**

DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page, because this was agreed to.
- Pages should not be legal sized, only standard sized, this seems ridiculous to even have to say.
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months. Things change substantially in 24 months- although I would find 15 months acceptable personally.
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation – THIS IS VERY IMPORTANT. IF THEY ARE NOT SENT IN TIMELY FASHION, A SUPLEMENTAL REPORT IS NEEDED. I do my reports the within 24 hours.
- If records are sent late, I do not want to be penalized and have to redo my report. The appropriate action is to do a supplemental report.
- It is most efficient and best for all parties if records are sent early enough to be reviewed before seeing the patient. Then I know what matters, what I need to ask about, what has been done, if pt should be at MMI. Can more accurately discuss causation, apportionment etc
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- I personally believe the mental heath modifier is fine at 1.5 or 2.0 at most—The reports are not that much more complex then pain or neurology reports. At that modifier will or certainly at 2.0x modifier, will have plenty of psych QMEs (my opinion). Record review for these specialists should pay same as for everyone else
- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)
- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this *prior to performing the service*.
- Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request

and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. I believe this can be done by both parties sending a brief- limit one page- letter to an arbitrator and that decision is final on the very narrow dispute of the reimbursement of the particular report.

- With all of the above said, the new proposed --agreed to fee schedule represent a significant step forward in fairly reimbursing QMEs, I personally will do more QMEs as part of my practice and I know other providers feel the same way, including all specialists. In addition, assuming the above comments are taken into account, The new proposed fee schedule is fair to all parties, simple, does not allow for trickiness on any side
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages. This matters as well – not doing this will lead to disputes.

Marjorie Cohn, Ph.D. July 8, 2020
Clinical Psychologist

It has been disheartening to see the proposed QME fee schedule changes recently put forth by the DWC, particularly in light of the mutual consensus that had been reached by various stakeholders.

I question the flat fee structure to begin with, as factors involved with cases can vary greatly. With a flat fee structure, the quality of reports could decrease on the very cases that need the most attention and consideration. The fee structure needs to take into account that QME's are preparing reports tailored to the specifics of each case. Likewise regarding the flat fee for record reviews, records can also vary greatly. For example, two hundred pages of lab reports would typically take a fraction of the time needed to review a twenty page psychological report. If a flat fee is the DWC's decision for record reviews, I question why the first 200 pages are non reimbursable, considering those pages could contain complex psychological, QME, or AME reports. I advocate for record reviews to be reimbursed where the records begin rather than at page 201. Reimbursement should be the $3 per page agreed upon and the definition of a page should be 8 1/2 x 11 with nothing less than a 12 point font.

Other mutually agreed upon conditions, such as medical records being sent fifteen days prior to the evaluation with a cover letter indicating the number of pages sent, should be adhered to. The following points should also be honored:

- Mental health modifier at 3x
- Expanding the definition of missed appointment to include for when the injured worker or interpreter leaves the appointment early, the interpreter does not appear for the evaluation, or the evaluation must be discontinued due to rudeness or intoxication on the part of the applicant.
- Sub rosa content does not have to be included in the original report if it is received after the date of the evaluation.
- "Remedial Supplemental " should be termed "Unreimbursed Supplemental" to indicate the type of report requested and should only be used in circumstances in which required issues were not addressed in the initial report.

In addition, the fee schedule should include a COLA adjustment as the fee schedule has remained the same since 2006.

Thank you for considering these points as you move forward.

Susan Velasquez, Ph.D., QME July 8, 2020

I am a QME and I find the proposed fee schedule to be completely inadequate. If this fee schedule were to be adopted, I would not find my role as a QME to not be cost effective, and I would have no option but to delist as QMEs. This would leave the QME system further decimated and ultimately harm the injured workers, particularly as psych claims are almost always initially denied, and a psych QME evaluation is imperative for the injured worker to receive treatment for industrial psych injuries. Additionally, I am a Psychologist of Color and I believe that my interviews of applicants of color adds a culturally sensitive approach to the QME process.

Below, is my feedback on the specific points of the proposed fee schedule that I believe are inadequate.

A modifier of 1.5 is not sufficient to compensate a QME in psychology or psychiatry. The modifier should be 3.0. The psychological interview requires a gathering of extensive information far greater than any other specialty. These interviews often take longer than three hours. The information must then be incorporated in a comprehensive report and a lengthy discussion of how each of these factors does or does not play a role in causation and apportionment. Psych is the only specialty that has a causation threshold of predominance. This requires a much more extensive and detailed discussion for both causation. Psychological reports also frequently require a lengthy discussion of personnel actions and a Rolda analysis, which takes further time.

The proposed fee schedule is suggesting $2 a page for records over 1800 pages. At the commonly accepted rate of 100 pages per hour, this works out to be $200 an hour, which is LESS than the current fee schedule rate of $250. This would be a pay cut rather than he described pay increase that this fee schedule calls itself. All pages need to be paid at $3 per page.

I need to receive records before the evaluation in order to perform a comprehensive history gathering. At the very least the cut off should be the day of the evaluation. If we are required to include records received at any time prior to issuing of the report, this is bound to cause delays in reporting and even late reports, which will just complicate the system, causing delays, denied reports, and requests for new panels.

Even the current fee schedule recognizes a nine-month cut off for re-evaluations. This being extended to 24 months is not acceptable. There is too much interim information to be assessed to be paid at the lower re-eval rate beyond 12 months.

The DWC must add an automatic annual fee increase so that QMEs are not without a raise for several years as has occurred since the last fee schedule change. A fee schedule that does not include this will be incomplete.

William Tappin, Esq. July 8, 2020
Tappin and Associates

At the time of the stakeholder meetings there was no discussion of per-page price being reduced to $2.00 per page after 2,000 pages. It was agreed that 200 pages would be included in the Initial Comprehensive Evaluation and pages thereafter would be paid at $3.00 per hour. It appeared that all parties were agreeable to that at the meetings and I have no idea how that was altered to $2.00.

I see no rational basis for the reduction from $3.00 a page to $2.00 a page. The entire idea is to disincentivize the parties from sending unnecessary or duplicative records.

Another issue that I raised at the meetings which I think should be addressed is the amount of time given to the doctors to prepare the Initial Comprehensive Report versus a Supplemental Report. It has never made any sense to me that the Initial Comprehensive Report be completed and served within 30 days while a Supplemental Report need only be prepared and served within 60 days. It seems counterintuitive. Ultimately, we want expeditious resolution of applicant's claims. It would seem to make more

sense to give the doctors 45 days for the Initial Comprehensive Report and 30 days for a supplemental report. That could be modified to indicate they have 45 days for a supplemental if they're sent over 1,000 pages of records. In that case, the initial and supplemental report would both be out in the same amount of time that is presently allotted. It would be 15 days faster if they're less than 1,000 pages of records. Additionally, we could give a 0.1 incentive to doctors who get their reports out in 20 days. Quite frankly, a lot of supplemental reports are merely answers to interrogatories from a party or the parties and could be done in 1 week. It seems to make more sense that the Initial Comprehensive Report should be allowed more time than a supplemental report.

I also suggested that in order to expedite the handling of applicant's case, that records be sent 30 days before the evaluation date and if they're not, and an additional day is provided to the doctor to issue a report for each day after 30 days that the records are delayed. For example, if the records are sent 15 days before the evaluation, the doctor gets an additional 15 days to issue his report. The main thing that doctors complain about is getting extensive records at the last minute. It puts the doctor under a great deal of pressure which of course may affect the quality of the report.

Code ML-204 is unclear. I think the meaning is that the physician should be paid a minimum of 2 hours for a deposition that goes forward which would include 1 hour of preparation and 1 hour of reserved deposition time. Additionally, if the doctor wants to review and sign the deposition [which I think all doctors should do], that should be an additional.

If a deposition is cancelled fewer than 8 days before the scheduled deposition date, the current language said they should be paid a minimum of 1 hour for the scheduled deposition. Some depositions are more complicated than others, and the parties reserve 2 or 3 hours. They should be paid for the amount of time reserved by the party scheduling the deposition. If 3 hours was reserved, the doctor should be paid for the 3 hours set aside. This will avoid any unnecessary confusion.

I think all of the stakeholders and clearly all of the doctors would agree with the above recommendations. Ultimately, it will mean a cleaner, more efficient and more expeditious resolution of claimant's cases. It will incentivize the records being sent promptly. There is really no downside to any of these recommendations. No one has ever been able to explain to me why a doctor gets 30 days for a comprehensive report and 60 days for a supplemental report. Some supplementals are 1 page long. We should reverse that and give 45 days for the comprehensive and 30 days for the

supplemental, which will result in both reports being completed 15 days earlier than the current regulations. The exception would be if the supplemental is as a result of the failure of the parties to send records, or the records exceed 1,000 pages in which case the doctor would have 45 days.

Please consider these potential changes. Clearly, the deposition fee ML-104 should have clearer language related to the time frames involved.

Dr. Lynn Lunceford, Clinical Psychologist July 8, 2020

I have been a qualified medical evaluator in the field of psychology since 2015. I wanted to share my thoughts on the proposed fee schedule changes. I consider myself to be very efficient as a report writer. I do psychological reports for the state, evaluating sexually violent predators and mentally disordered offenders. I have developed many time-saving tools over the years and, consequently, get my work done quickly. Even so, the qualified medical evaluation is the most time-intensive evaluation I do. In assessing the applicant's psyche, I have to assess aspects of their entire life (childhood, work history, psychosocial history, past traumas, and past medical, surgical, and psychological illness and treatment. Then I also have to evaluate for mental illness. I typically spend hours preparing for the evaluation, including reviewing records. I then spend typically two hours interviewing the applicant and then 15-20 hours writing up the case, depending upon the complexity. I have no way of shortening that given what is asked when one is evaluating a psychological injury. As much as I enjoy this work, I know I will not be able to continue it if the new fee schedule is enacted. The pay would just not be sufficient for the number of hours such a report requires in order for it to be a solid report.

Danny L. Keiller MD, FACS, QME July 8, 2020

I am a California Qualified Medical Evaluator. I am understandably shocked and chagrined at the direction your latest proposals for a new QME fee schedule is taking. After presumed good faith discussions and proposed changes based on Sue Honor's recommendations, that were supported by many of us working in this field, your disregard for the process is upsetting, to say the least. I simply cannot understand your inconsiderate reasoning in arriving at the latest new rules you are considering. Other QME colleague friends and acquaintances also cannot fathom why you are neglecting the early proposals and subsequent healthy process that has occurred to date.

Please reconsider the prior discussions and agreements that have been worked out. The QME process will likely not survive if your neglect of simple things such as lack of appropriate living wage increases for more than a decade, failure to make insurance companies send medical records in a timely manner and disallowing the requirement that insurance companies acknowledge the page count of medical records and index and chronologically arrange the records for an applicant's evaluation.

I am proud to be a California QME who acts as an impartial spokesperson for both applicant and insurance carrier. Please allow me to continue my important and vital job by providing adequate rules for both applicant and defense and adequate reimbursements for those of us that devote much of our professional work to this important process.

Dr. Mark M. Kosker July 8, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,800 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

Sue Honor's proposal and the accompanying petition can be found here: https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor

reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Carl Shin, MD July 8, 2020

CSIMS position on necessary revisions to DWC fee schedule proposal

1) a page of records must be defined as double spaced, single sided, 12point or greater font, 81/2' by 11' with no condensed deposition transcripts
2) The party that submits medical records must list the records provided and attest to the number of pages under penalty of perjury. Page counts must include cover letters and any and all documents provided. Records should be submitted electronically and every page in the file counted. Records received less than 15 days prior to the date of the evaluation may be submitted as a supplemental report.
3) The fee for reviewing a page of medical records should be $3 regardless of how many pages are submitted and regardless of the type of report requested
4) A re-evaluation is an exam requested within11 months of a prior exam and where the applicant is available for evaluation within 60 days after the request. If these conditions are not met, then it is a new evaluation
5) The AME modifier should apply to all fees and all services. This includes medical record review, supplemental reports, depositions and examinations.
6) The psychology/psychiatry modifier should be at least 3x
7) Internal medicine, neurology, and pain medicine modifiers should be at least 2.0x
8) The 1.5 modifier for toxicology and oncology should apply to all reports for which toxicology or oncology is the primary focus.
9) Any physician requested to perform research should be able to bill by the hour, the number of hours by agreement prior to preparing the report
10) The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable. The DWC should retitle this "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this *prior to performing the service*. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b) or failed to answer

a specific non-hypothetical question not requiring research. Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

11) An automatic annual COLA increase should be included in the fee schedule. We recommend using DWC's own metric of Statewide Average Weekly Wage as the basis for the automatic, self-executing COLA increase.

Dr. Howard Greils MD July 8, 2020
Psychiatrist

In in response to the proposed changes to the Reimbursement of Medical-Legal Expenses:

It is clear that the authors of this proposal are not acquainted with the complexity and infinite number of variables involved in producing a comprehensive medical-legal psychiatric evaluation report.

Hopefully the following information will help to influence the decision-makers to abandon this proposal.

First of all, there is the issue of the flat fee for a medical-legal report for psychiatric evaluations. Often there are two or three or more injuries, and each has to be carefully studied, evaluated and analyzed. There might be one cause of injury - or many causes, and each of these has to be carefully considered and apportioned. In the latter cases, the analysis requires a great deal more time than in the former case. Therefore, one payment standard for each of these cases cannot be appropriate or adequate to cover costs. There are additional complicating issues. For example, in a psychiatric evaluation, if there is any possibility of causation by lawful, non-discriminatory, good faith personnel action, a Rolda analysis is required. This demands a careful study of every event that has occurred in the workplace and assignment of a percentage of cause so that the trier of fact can determine if there is substantial contribution from that cause. This can be extremely time-consuming. Or - sometimes the applicant is a poor historian and his or her reporting is unclear. These cases require extensive time comparing the applicant's reporting to the information in the medical records, and to deposition testimony, etc., in order to arrive at a fair understanding of the history and arrive at fair conclusions. This extra time requires additional compensation.

The second, and even more problematic, issue is that regarding compensation for the review of medical records. The proposal suggests that a review of 200 pages of records should be included in the flat fee being offered for the completion of an initial QME medical-legal report and that any further records be compensated at two dollars a page. This is ill-informed in that it appears to assume that each page of medical records is relatively equivalent to any other page. This is FAR from the reality. At times, there may be little to no significant information on a single page, but often, one page may contain dense and important information that requires a lengthy period of time to summarize and to consider. For example, most deposition transcripts are presented in condensed form with four to six pages of important testimony printed on a single sheet of paper. Deposition testimony is essential medical evidence. A fair conclusion cannot be reached without careful study, summarization and review of this evidence - which is extremely time-consuming. Also, as a psychiatric evaluator I often have to carefully review historical psychotherapy progress notes. These can be dense and filled with important information. Further, these are often handwritten and may require extensive time to study and interpret. Appropriate compensation is necessary for this task.

The authors of this proposal are also apparently unaware of the manner in which medical records arrive. Often, many additional hours are required simply in order to sort them by date and provider, eliminate duplicates, and determine which documents are relevant. Also, of late, medical records are more often arriving electronically or in digital form on compact discs. Sorting through these documents in this form takes even longer than hard copies. Another issue is that there is often video surveillance footage. The evaluator is often asked to scrutinize such video as part of the medical record. How would this even be counted? There is no way to predict how many hours 200 pages would take to review and assess given the complexity of a psychiatric evaluation and I would recommend that the 200 pages not be included in the flat fee.

All in all, it is extremely important that it be understood that all medical record review time needs to be compensated separately from the preparation of the report so that the each of the variables can be appropriately considered and compensated.

A third issue is that of the proposal of a flat fee payment for supplemental reports. Similarly to above, the first 50 pages should not be included in the flat fee for the same reasons. This is likewise ill-informed for the same reasons as those discussed above regarding evaluation report, i.e., the vast variability in these reports. And further, the authors may not realize that, often a supplemental report is issued in response to an attorney’s interrogatory. This may involve responding to multiple complex questions involving legal and medical issues, and the time demands of such a report can vary widely. Therefore, a flat fee is totally inappropriate.

I truly believe that a modifier of 3.0 for psychiatric evaluations is a more tenable solution.

In summary, I am hopeful you would consider the above a more fair minded solution to the medical legal fee schedule issue.

Janice Skiljo Haris, R.N., B.S.N., M.S.N. July 8, 2020
MEDLink
Shawn King J.D., SOS Consulting

The DWC's latest iteration of a proposed medical-legal fee schedule should be in the main praised as an improved proposal. Indeed, so much so that one ought to remember the adage attributed to Voltaire: "The best is the enemy of the good." The point being, while there is room for relatively minor discussion of some points of the latest proposal, in the main the DWC has done quite excellent work.

In the interest of brevity, we will not belabor areas that we find well explained or well set forth. Rather, we shall focus on the areas where we find that some modifications could help the proposal.

ML201 Comprehensive Medical-Legal Evaluation And 'Record Review' Fees

First, we appreciate the proposed allocation of $2,015. However, the issue of charges for pages of records reviewed is an interesting one. For years we have been advocating that carriers in particular would be much better served by having $15-$20 per hour staff sift through medical records and extract duplicates than having those same records sent to a QME/AME where the hourly fee is far higher. One hopes that the language already in the proposal makes the logic of such an approach plain to carriers.

However, where the proposal frankly seems odd is in an arbitrary reduction in the fee for pages in excess of 2000. Is the process of reviewing records felt somehow easier when a mountain as opposed to a molehill is confronted? While in the main (exceptions to be explained in a moment) a page is a page, the draft proposal would have one believe that a truly huge submission of records is somehow easier to get through it than a small pile. The opposite is true. The more thick the tome, the more likely that multiple attempts to get though it will be necessary. That means having to retrace steps to some extent and to get back into the mental place one was in when previously sorting through the records maze. We suggest to keep the fee of **$3 per page** the same for page after page, even greater than 2000 pages.

We would also note that the pages battle is one that could be fraught with gamesmanship. While four pages of text on one, condensed depositions are easily addressed via page numbering, the font size used in such records could become an

issue if regularly utilized for submission of records in general. We suggest that when singly generated pages are produced, the font size matters. With the exception of items akin to the page noted depositions, single pages of records should not be submitted so as to "miniaturize" the pile. Frankly, we don't have a ready solution to this, but note that consideration for a minimum font size could be considered.

ML202 Follow-up Medical-Legal Evaluation And 'Record Review' Fees

Second, the timing for follow-up medical legal evaluations has rightly been increased from the currently existing nine-month window between exams. However, in extending the window to a greater opening, the effort overshoots the mark somewhat. Complex litigated cases, or simply cases in which care needs or other reasons are extending matters tend to generate both lots of paperwork and lots of twists and turns. Twenty-four months is long enough for recollection of a patient to fade, and efforts to necessarily essentially begin from scratch. To reduce the effect of spiraling complexity, we suggest follow-up evaluations use a twelve (12) month window to allow the parties a reasonable timeline for resolution.

While we appreciate the proposed increase for a Follow-Up Medical-Legal Evaluation, we recommend the flat fee of $1,500 to start to include the first 200 pages and allowance for a doctor to review what, in our experience, usually includes multiple prior records, multiple prior medical-legal reports, supplemental reports and possibly a deposition.

We also suggest keeping the fee of **$3 per page** the same for page after page even >2000.

ML203 & ML206 Supplemental Reports And 'Record Review' Fees

While we find that the fee of $650 for supplemental reporting in general is fair, the criteria surrounding supplemental reporting is rife with the seeds of conflict.

For example, if an evaluator simply misses an issue, we agree that a supplemental produced to correct the oversight ought not be a chargeable event. However, often times issues are not addressed because the parties to an evaluation (particularly an AME) are not in agreement as to the scope of the evaluation. One side may list issues one through six, the other only issues one through four, or add issues not mentioned in the opposing sides' correspondence at all. To avoid being ensnared in the conflict and to avoid taking sides, doctors often will only answer the questions reflected in correspondence from both sides. If the parties later clarify matters, the doctor hasn't overlooked or neglected anything – but the current draft regulation could interpret that situation as one in which the doctor failed to address a previously requested issue.

Likewise, 'form' generated cover letters are very often internally inconsistent. The

'form' portion of the letter conflicts with the text specific to the fact pattern of the particular case. In this instance, while the letter is typically coming from only one side, the letter itself presents internal conflict.

Further as to this issue, supplemental reports often address the same issue repeatedly. This because one of the parties to the case simply doesn't like the answer given as opposed to the answer being incorrect. As worded, one could readily see billing disputes arising because bill review will interpret the supplementals as merely addressing points already asked. We suggest the provisions concerning supplemental reporting be restructured to retain non-payment only for a supplemental addressing material that was already on hand before production of the evaluation report as well as non-payment for supplemental reporting necessitated by simply overlooking an issue that was not in dispute. Finally, there should be a requirement that the Cover Letter to Doctor with medical records be mailed by proof of service 15 days prior to the evaluation or the supplemental will not be considered a clarification, but a billable ML203.

We also suggest keeping the fee of **$3 per page** the same for page after page even >2000.

ML204 Deposition Fee

We appreciate the proposed allocation for a deposition fee of $455 per hour. However, with respect to cancellation of an appointment for medical-legal testimony, we suggest that the fee for a cancellation less than seven (7) days should reflect the minimum charge of two hours. While a doctor may indeed use the time set aside for the actual deposition for other work, thus mitigating losses, there is no recovery for any time already devoted to preparing for the deposition, nor for the loss of what could have been put into the cancelled appointment time, as even the seven (7) day window is quite usually too short to allow for a replacement event.

ML200 Missed Appointment Fee Should Include A Late Cancellation Fee

We appreciate the proposed allocation for a missed appointment fee of $503.75. However, with respect to any late cancellation of an appointment less than seven (7) days, we propose the same missed appointment fee apply.

Modifier -94 Evaluation Performed By An Agreed Medical Evaluator

We appreciate the inclusion of the AME modifier fee. However, we propose that there is clarification that the AME modifier will also apply to all MLFS codes: 1) ML201 Comprehensive Medical-Legal Evaluation; 2) ML202 Follow-up Medical-Legal Evaluation; 3) ML203 Supplemental Report; 4) ML204 Deposition; 5) ML200 Missed Appointment.

Modifier -96 Evaluation Performed By Psychiatry or Psychology

The fees for evaluations performed by a Psychiatrist or Psychologist are recognized by the draft proposal as being distinct from most other evaluations. However, the modification suggested remains somewhat low in terms of being a reasonable compensation given the time spent in the average such evaluation. We suggest the base fee for evaluations performed by a psychiatrist or psychologist be increased to: $3,500 for initial evaluations and $2,500 for follow-up evaluations. We also propose psychological testing fees per OMFS continue to apply.

Ezekiel Fink, M.D. July 8, 2020

I think the current proposal misses the mark. There are many issues and I am going to highlight several:

- The 14 inch page proposal for medical records is pretty offensive.
- So is the idea that we should have to write reports for free. There is no way to explain this one to me that would be ok.
- I am not sure why the AME modifier should not apply to the entire report. That seems arbitrary and punitive as well.
- I get quite a few complex cases and have to spend time researching. I am not sure why this should not be compensated time. That seems arbitrary and punitive.
- The fee per page of record review is not currently adequate, and should be raised to at least $3.50 per page There should be standard rates across all records reviewed and not arbitrary cutoffs. That seems arbitrary and punitive.

Please make reasonable adjustments for the sake of the clinicians and patients in this system.

Martin V. Ross, Ph.D., Psy QME July 8, 2020

I have been a QME for over three decades. I am a psychologist and I conduct QME and neuropsychological evaluations. I have learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

Unfortunately the DWC violated the stakeholder agreements in order to favor the insurance carriers.

DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- The mental health modifier should be increased to 3.0x
- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)
- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report
- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their

intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this *prior to performing the service*. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

If there is further reduction of the reimbursement, the number of QMEs will be reduced. I for one will probably just retire from the system,

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David Abri DDS July 8, 2020
Abri Dental

I realize that we're all trying to do our job and to do it right. I humbly ask that you keep an open mind when reading this email. I respectfully like to bring up some issues with the new proposed fee schedule.

I have learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payers and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

I think the entire QME community was looking for a COLA raise. But in my opinion, that is not happening. As a matter of fact, I think that the QME fees are being reduced.

The main issue I have with this new fee proposal, is this: Why is it that after 2000 pages the page fee drops to $2? This seems **counterintuitive** to me. The more the pages there are, the more to account for, and therefore more complexity. It seems with this new proposal, the more complex the case gets, the lesser is the reimbursement.

It's also a bit insulting, because to assume that it's okay to drop the page value to $2 after 2000 pages, seems like you're asking for a wholesale bargain. But in reality, the

time I spend on these pages are the same. I don't think it's fair that I get paid less for my time, while the payor gets a wholesale discount. This type of thinking is very flawed.

Second is the definition of a page. A page is 8.5 by 11.Let's not make it any bigger. This is a big administrative hassle for me and my office. And again, it seems like another way the payor is making this into a wholesale deal.

Regarding re evaluations of 24 months is not acceptable. It needs to be less than a year. So much can change in 24 months.

The AME modifier should be 1.5.

And why shouldn't the carrier send us the records 15 days prior to the report? We all have busy lives. Why should the QME scramble at the last minute and have to rush through records in order to turn in the report on time? The QME's time is valuable and we need our records in order to plan our weeks and months to be able to turn in quality reports. You guys want quality reports, then please listen to our request and get us our records on time.

The fee schedule should include an automatic annual COLA increase for QMEs. Why is the QME not getting a COLA increase? Everyone gets a COLA increase. Why are we being discriminated against?

Finally, regarding "remedial supplemental evaluations". DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." The scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). And there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. Please realize that by giving the carrier the opportunity to ask the QME for free reports, is a huge potential for abuse.

Edward D. Jennings DC, DABCN July 8, 2020
Jennings Chiropractic Neurology Clinic

The proposed changes are unacceptable. If enacted, this fee schedule will increase the administrative burden on QMEs, not compensate them fairly, and undoubtedly reduce the already record-low number of QMEs still left in the system.

I am QME for 15 years. I have learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by the DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that

DWC did not honor the terms that were agreed upon in the QME stakeholder process. Unfortunately (but not surprisingly given DWC's demonstrated track record of bias towards insurance company interests and against injured workers and medical providers), DWC violated the stakeholder agreements in order to favor the insurance carriers.

Specifically, DWC made the following changes against the stakeholders' wishes:

	DWC Stakeholder Meetings	**California DWC Proposal**
Reimbursement per page	$3 (starting on page 201)	$3.00 (pages 201 – 2000) **$2.00 (pages 2001+)**
Definition of page	8 ½ x 11"	8 ½ x 11" OR **8 ½ x 14"**
Definition of re-evaluation	9 or 12 months	**24 months**
AME Modifier	1.25x and applies to **all services**	1.35x but applies **only to flat fee and not to depositions**
Medical records required to be sent 15 days prior to evaluation	Yes	**No**
Cover letter required to specify number of pages sent to doctor?	Yes	**No**
Automatic Annual COLA Increase?	DWC refused to hear this issue in the stakeholder meetings	**No**

DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- <u>The mental health modifier should be increased to 3.0x</u>
- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)
- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report
- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***.

Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.

- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Steven D. Feinberg, M.D.
Board Certified, Physical Medicine and Rehabilitation
Board Certified, Pain Medicine
Adjunct Clinical Professor
Stanford Anesthesiology, Perioperative and Pain Medicine Department
Stanford University – School of Medicine

July 8, 2020

There have been numerous comments on the Forum and while I share many of those concerns, I am only going to reiterate a few of them as I want to emphasize some other ideas and approaches while providing comments that are meant to be positive, additive and problem-solving. I also want to point out areas in the proposal that could have unintended negative consequences.

While I understand fully that the current proposal on the website form is not final, and that all elements are subject to revision, considerable angst, distrust and anger towards the DWC has been created by stepping back from the stakeholders' agreement.

On the positive side, thanks to the DWC for acknowledging the need for increased reimbursement above the current ML102 (Basic) and ML103 (Complex Comprehensive) reports, for Medical-Legal Testimony (ML-204) and adding reimbursement for missed appointments (ML-200).

Recommendation: Please expand the definition of missed appointment to include injured worker leaving before completion of exam, interpreter not showing up or leaving prematurely, or discontinuation of the evaluation by the QME due to age and worker redness, abusive behavior, or intoxication.

Time-Consuming & Complex Cases: As discussed in the stakeholders' meetings but never solidified in terms of a final opinion, a mechanism is needed when there is a time-consuming and complex case with limited medical records to reimburse the QME adequately.

Regarding the base rate fee + per page reimbursement: There is only a loose association between the number of pages of medical records and the complexity of the case and the time needed to prepare a report. QMEs legitimately have concerns that a very complex and time-consuming report may not be associated with a large medical file thus limiting reimbursement despite long hours spent on preparing a report. While particularly true for mental health cases, complex and time-consuming cases are spread throughout the other specialties as well. Many QMEs, and particularly mental health practitioners and physicians who do more complex cases and those who spend more time face-to-face with injured workers and/or do research, worry that they will not be provided adequate compensation for the time spent.

Recommendation:

1. **Allowing for an additional 3.0 hour fee ($325 X 3 = $975).**
2. **Provide a mechanism such that the applicant attorney/injured worker and defense attorney/payer can agree for the QME to be paid an hourly QME rate ($325) for cases which obviously are more complex and time-consuming.**
3. **Provide a mechanism which allows the QME to opt out when the complexity of the case is such that the standard fee provided does not cover the time involved to provide a quality QME report.**

Regarding the increased flat rate for supplemental reports (ML-203) plus a per page fee after 50 pages, on the surface, that would appear beneficial but some supplemental report requests are highly complicated and time-consuming and may involve providing a full permanent and stationary report where the base rate will not cover the time needed to complete a quality report.

Recommendation: While the fee of $625 covers 2 hours of time, a mechanism is needed to cover situations where there are few provided medical records, yet a complex and time-consuming supplemental report is needed. The simplest solution would be to allow supplemental reports that include a permanent station determination to be paid at the ML 202 rate of

$1,316.25. Regardless, there should be a mechanism for the parties to recognize ahead of time that a supplemental report will be complex and time-consuming and allow for additional charges or the QME should have the opportunity to request additional payment. Frankly, the easiest solution is to allow the QME to bill by the quarter hour for the entire supplemental report.

Regarding Agreed Medical Evaluations (AMEs), while the 1.35 modifier is appreciated on the base rate, there is no reason to go back on the current system especially when the stakeholders' group recommended continuing the 1.25 times the entire charge including the base rate and the per page fee for all codes. The AME population is already limited and may erode further absent extending the modifier.

Recommendation: The AME modifier should include the base rate and the per page fee to be applied to all codes.

Regarding reducing costs and yet fairly reimbursing QMEs**:**

Recommendation: Although brought up during the stakeholders meetings, there is no mention of the DWC putting into place a system where both the applicant attorneys and the payers use a "clearing house" to remove duplicates and index the medical records which would then be available to the QME on the Internet or via CD (paper records could still be provided). By removing the significant cost to the QME of sorting, removing duplicates, and indexing/ordering the medical file, there is less justification for provider complaints regarding the current recommended reimbursement levels. This simple solution which is already available today is a win-win for all parties. The applicant attorney can be assured that the physician has all the medical records, the payer can be assured that the physician is not charging for duplicate pages (this can be substantial and as many as one third of all submitted records are duplicates) and the QME benefits with the cost saving of not having to handle, sort, and index medical records/put them in order. Further, it allows any of the concerned parties to have access to the full medical file at any time. Various vendors could receive DWC certification to serve in a clearing house capacity.

Regarding the current PR-4 system, it works well for many simple cases, but it is not highly reimbursed, is avoided by many treating physicians, and may lead to contention, further litigation and ultimately requesting a QME or AME.

Recommendation: This recommendation is to strengthen the role of the PTP who obtains QME certification. Currently, "disputed" cases can be billed as a QME by the PTP. The problem is that the determination of what

is "disputed" and what is not is sometimes in the eyes of the holder, i.e., the applicant attorney/injured worker or the payer. A solution would be to allow the PTP who is also a QME to provide a final report using the medical legal fee schedule. This has many ramifications including more physicians choosing to treat injured workers, more PTPs becoming QMEs, and the avoidance of lengthy litigation with going to the DWC to obtain a separate QME or the need for an AME.

Higher reimbursement for disputed cases and permanent stationary reports: The new system includes ML-201 (Comprehensive/Initial Evaluation) versus ML-202 (Follow-Up Evaluation): The system put forth does not distinguish whether the examination involves a permanent and stationary report and/or addresses disputed issues (AOE/COE, body parts involved, etc.). The flat fee plus per page fee makes some sense when it comes to spending time face-to-face with injured worker and reviewing the records. As mentioned above, it does not correlate with time spent on analysis and integration of data and case conceptualization.

Recommendation: Absent addressing a contentious issue and/or provision of a permanent and stationary report, the initial evaluation should be paid at a lower rate (i.e., ML-202 fee). If the report addresses a contentious issue and/or provides a permanent and stationary report, the higher fee should be paid (i.e., ML-201 fee). To put it more specifically, the higher fee should involve a permanent and stationary report or addressing disputed issues.

Resolving the Mental Health and/or Complex Case Dilemma:

Recommendation:

1. **Increase the modifier for mental health cases and/or**
2. **Assuming addressing a disputed fact (i.e., AOE/COE, etc.) is requested or a permanent & stationary report is provided, in addition to the 1.5 modifier, then an additional 3.0 hour fee ($325 X 3 = $975) is allowed or the fee for the submitted pages - whichever is greater.**

Consider a Totally Different Approach:

1. **Recommendation: As recommended by Dr. Rick Newton, revisit and update the current MLFS.**
2. **Recommendation: Recently CAAA recommended returning to the prior system of each side obtaining their own evaluator. The parties can still agree to an AME, split the difference between the competing evaluators, or allow the judge to accept the most cogent evaluator's opinion. In the non-workers' compensation IME world (Civil or 3rd Party Cases), each side picks their own evaluator and pays for it. Physicians compete for business based**

on the quality of what they do and to some extent, based on what they charge. There is an argument that this system is one where you get what you pay for.

3. **Recommendation: Consider a tiered model where the parties would be encouraged to 1) settle on the reporting of the PTP, 2) be strongly encouraged to use an AME, and if they could not agree on one, then the 3) WCAB Judge would choose an evaluator (paid equivalent to the AME). All physician evaluators would have to be certified QMEs or designated/chosen as the AME. The DWC's role would become one of education and monitoring.**

Andrei Novac, MD, DFAPA
Diplomate, American Board of Psychiatry and Neurology
Clinical Professor of Psychiatry
University of California at Irvine

July 8, 2020

I am a medical doctor and a psychiatrist who has served the Workers' Compensation System for over 30 years. I have been a QME since the QME system was instituted, and I have served as a psychiatric AME on numerous cases over the past 30 years. I am writing to strongly object to the current proposal for a revised QME fee schedule.

The DWC has not honored the negotiated fee schedule and has thus violated the stakeholders' agreement from last year's stakeholders meeting.

Specifically, certain details will make it impossible for a QME to be even remotely compensated for complex cases, in which the most vulnerable and in need of extensive medical care injured workers are involved. Ultimately, the partial "defunding" of QME fees for complex cases will have disastrous consequences on caring for injured workers.

Here are some specifics in the discrepancy between the agreed-upon negotiated numbers at the stakeholders meetings and the current proposal:

- Reimbursement per page: instead of $3.00 per page overall, now is $2.00 per page beginning p 2001;

- The definition of what constitutes a page of records has been stricken;

- Medical records were supposed to be delivered 15 days prior to evaluation, but now there is no such deadline;

- The cover letter was supposed to specify number of pages sent to the doctors to avoid expensive disputes, but now such requirement is eliminated

We are demanding that the QME fee schedule be rewritten to honor the results of negotiations from the stakeholders meetings and make additional corrections to make the evaluations of complex lengthy cases feasible. By doing so, it provides remedy for many injured workers.

Such demands are:

- All pages over 200 should be reimbursed at $3.00 per page;
- Pages should be standard size and not legal size; this needs to be clarified;
- Re-evaluation should be 9 months after initial examination, as it is now, and not 24 months;AME modifiers should be 1.25x and apply to all services, including per page fee;
- Medical records should be sent to QMEs at least 15 days prior to exam;
- Cover letter should specify number of pages sent to QME;
- Mental health modifiers should be absolutely an increase to 3.0x;
- Neurology and internal medicine should be allowed a modifier of 2.0x;
- The definition of a missed appointment should include: instances where injured workers leave prior to completion of exam; instances where interpreters don't show up or leave prior to completion of exam; or examination has to be discontinued by QME due to rudeness or abusive behavior of injured worker;
- Cut-off date for QME to include records or *sub rosa* in the face-to-face evaluation report rather than a supplemental evaluation should be the date of the examination with the delivery of all the records 15 days prior;
- The so-called "unreimbursed remedial supplemental evaluation" should be redefined; it should remain as "unreimbursed supplemental evaluation"; the scope for such a request should be very narrow, stated in the letter, and should be allowed for only if the QME violated 10682(b). There should also be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation.

There are specific concerns about this last point, as it indicates a willingness to allow for unchecked, unfair flooding of additional work placed upon the QME that could serve as a deterrent and intimidation to further service as a QME for future cases.

Jeffrey A. Hirsch, MD July 8, 2020

I am writing to express my dismay at the anticipated adverse impact of these proposals on individuals who are injured at work. Through two decades of providing treatment for these injured patients, and also providing forensic analysis of their claims, I have observed steady erosion of the system that is intended to support them and address their injuries. What happened to the “grand bargain” upon which the Workers’ Compensation system was erected? With all the changes I have seen in the system over these decades, almost every single adjustment accrued to the detriment of injured workers.

This fee schedule will be another nail in their coffins, because high-quality physicians and other related experts will continue to flee the system. It is no secret that about half of the active QME’s have quit the system in the last decade; and I can echo others who point to the older age of many of the providers still working as QME’s. So with this fee schedule, that attrition will continue, causing further hardship on injured workers (who are unable to see a quality physician in a timely manner, in many cases, even with the current level of participation).

Even the least cynical amongst the stakeholders must be aghast at the lack of good faith in this painstaking process of crafting a new, mutually-acceptable fee schedule. A variety of agreed-upon parameters were simply discarded.

For instance, I find it particularly provocative to advance the idea that one “page” of medical records can extend to 14 inches. It is almost as if some lobbyist suggested this as a tongue-in-cheek idea, with no chance of traction, and yet there it is. Have you been to an office that produces medical records on 14 inch paper? I have not seen that in more than 30 years as a physician. And, furthermore, in attorneys’ offices, only the yellow legal pads or lengthy contracts are on 14 inch paper.

In studying the proposals closely, I strongly suggest the following changes to achieve some degree of equitable compromise:

1. a page of medical records is 11 inches, double-spaced, with 12-point font (or larger).

2. records MUST arrive 15 days before appointment, or they are not included in the calculation of fees for that report.

3.AME modifier should apply to all fees, not just the flat fee for reports.

4. Modifier for toxicology and oncology should apply to ALL reports for which those issues are a major focus. No doubt the DWC is aware that probably only several dozen board certified toxicologists and oncologists exist in the QME system in the entire state. Therefore, these modifiers, as currently proposed, are spurious and not in good-faith.

5. Evaluators should be able to arrange fees for necessary research, paid on an hourly rate, by communication with the parties in the specific case.

6. The cut off for re-evaluation reports should be less than one year, not out to two years.

7. The mechanism proposed for supplemental reports or "remedial" reports is not workable. The quality of such reports will drastically decline if physicians are tasked to work for free, or for minimal payment.

8. Cost of living increases should be automatic, built-in to the system, and NOT dependent on any specific DWC action. The cost of living increases should be triggered only by the passage of time. Physicians have been terribly burned by dependence on good-faith governance by the DWC. This reality should be evident to anyone observing the passage of 14 years without an increase in fees to offset the massive increase in expenses over that period of time.

9. The fee per page of record review is not currently adequate, and should be raised to at least $3.50 per page. Furthermore, I can find no logical argument for discounting the price per page after some thousands of pages. It takes me just as much time to study and summarize page 2,001 as compared to page 1,999.

The idea that medical-legal costs are out of control is a frequently-stated justification for this draconian fee schedule; yet the claim does not stand up to scrutiny. Actual data analysis shows that med-legal costs were 6% of total system cost in 2013 (total cost $4.9 B) and, again, exactly 6% of total system cost in 2019 (total cost $4.4 B).

In summary, the wide gulf between the negotiated agreements with DWC and this fee schedule will accelerate the disintegration of the Workers' Compensation system in California, and the one group who will suffer most is the community of injured workers.

Cynthia Davis, M.D. July 8, 2020

I have been a QME specializing in otolaryngology for the past 20 years. Over the years, I have noted the increase in complexity and associated work in preparing medical-legal

reports for my worker's compensation patients. My staff are astonished at the large boxes of records that I receive for medical record review for those patients. In the past, I could perform an exam, medical record review and report preparation in 3-4 hours. Now, I find that it generally takes several hours (at least 10-12) to review the extensive records and address the multiple questions presented by the worker's and defendant's representatives. Initially, reimbursement was more commensurate with my time requirements, however over the past several years, without an increase in reimbursement, my cost of running an active medical practice now far exceeds the reimbursement I receive for my medical-legal reports. I am one of the "younger" otolaryngology QME's from my area and I am in my mid-60's and wonder why I continue working as a QME with the current reimbursement rates. I have also tried to recruit other otolaryngologists to become QME's and they find that the current reimbursement rates very unattractive.

One of my patients today was a worker's compensation administrator and she lamented that she has so many workers that are placed in limbo waiting for months or years, to get a QME evaluation, to allow for their claims to be adjudicated. She noted that the QME exam is "the cog in the wheel" for her worker's claims to progress forward.

I have followed the stake holder meetings regarding a new medical-legal fee schedule. I saw some encouraging results early on but am very disappointed with the currently proposed fee schedule. More or less, this was a bait and switch offer. You took our concessions and then did not stick with your proposals.

Specific concerns are:

Our fee schedule is woefully low for the work required. My overhead is hardly covered by the $250/hour that we are currently being reimbursed. We have higher office rent, employee salaries and other costs as compared to other states and we are reimbursed less than our neighboring states.

As physicians, we can do basic math. It is not any easier to review the first 100 as compared to the last 100 pages during medical review and it does not make sense to be paid a discount for reviewing greater than 1800 pages. Rather, I would propose increasing reimbursement on larger charts as I find that I not only receive voluminous records on my patients but there is no effort placed on the Insurance Carriers to provide us with more limited, diagnosis specific records. That would allow us to spend more time on seeing the workers and getting their reports prepared in a timely manner. I often have to count the number of medical records that I receive, another waste of physician's time. I often receive medical record in both CD and paper form with duplications. Unfortunately, I have to review page by page to determine what is new and what is a duplicate.

I often receive the worker's medical records a day or two before or days following their exam. It rarely allows me enough time to review the records before the exam. I am "flying in the dark" without the records and it is unreasonable to review 1000 or more pages the day before an exam. We need the medical records available at least 2 weeks before the exam.

The size of print font and paper size needs to be specified in the fee schedule.

We have not had a cost of living increase in 14 years. Our cost of maintaining our practices has increased significantly, especially now that we have increased PPE and safety requirements related to the COVID19 epidemic. We need an annual COLA review and increase to the fee schedule.

I am at the crossroads as to whether or not I will continue to serve as a QME. I enjoy meeting and evaluating the workers and believe that they need to be cared for when injured at work. I also believe that we need to be good stewards of the State's resources and need to determine if their injuries are related to their work. Unless the medical-legal fee schedule is significantly updated and improved, I will need to resign from serving as a QME.

Samir Sharma MD July 8, 2020

I am a strong proponent of the new fee schedules for med legal fees. The previous system is arcane and complex. There is a lack of QMEs in the state of California. There has been zero cost of living increase over the past 20 years.

Bernard Monderer, MD July 8, 2020

I am QME. I have learned that CSIMS and other provider groups met with DWC over the past several months in stakeholder meetings hosted by the DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process. Unfortunately (but not surprisingly given DWC's demonstrated track record of bias towards insurance company interests and against injured workers and medical providers), DWC violated the stakeholder agreements in order to favor the insurance carriers.

Specifically, DWC made the following changes against the stakeholders' wishes:

	DWC Stakeholder Meetings	**California DWC Proposal**
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AME Modifier	1.25x and applies to **all services**	1.35x but applies **only to flat fee and not to depositions**
Medical records required to be sent 15 days prior to evaluation	Yes	**No**
Cover letter required to specify number of pages sent to doctor?	Yes	**No**
Automatic Annual COLA Increase?	DWC refused to hear this issue in the stakeholder meetings	**No**

DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months

- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- <u>The mental health modifier should be increased to 3.0x</u>
- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)
- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report
- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of

such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.
- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Jim Platto, MPH DC QME July 8, 2020

My only suggestion would be under ML200 for 'missed appointments.' If the schedule appointment is unable to go forward because the certified interpreter did not show, the ML200 fee schedule should also apply.

Ashton Wolfson July 8, 2020
QME Management Group

Although the proposed fee schedule is a vast improvement over the previous proposals in recent years. But, iit still comes up woefully short.

I believe that the new medlegal proposal should be equal to or higher than Nevada's IME Med Legal fee schedule. California's cost of living and over regulation should be considered when it comes to the new fee schedule. Not only is the current CA proposal's compensation low, the proposed schedule also has many areas that are subject to interpretation. This will once again provide more opportunities for the Discipline Unit to interpret the code as they see fit to punish folks. It's no surprise that in the past the Discipline Unit was more than willing to interpret the fee schedule in order to punish QME's and wreck their career.

If the DWC is unwilling to make the proposed fee schedule rates comparable or higher than that of Nevada, Maybe they should consider re-working the current fee schedule. At least, everyone knows how to apply the current fee schedule. If the new schedule is approved, prepare for mass chaos in CA work comp system as California's current crop of QME's try to navigate the new billing practices.

RECOMMENDATIONS

- All pages over 70 should be reimbursed at $4.25/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report

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Joseph Matan, MD July 8, 2020

I am a long time orthopedic QME and former member of CSIMS. I fully support the CSIMS position on the proposed fee schedule. The results of the stakeholder meetings should have been used for the new schedule.

Lawrence I. Stern, Esq. July 8, 2020
Mallery & Stern

What would be best for my clients, the injured workers, is a useful and efficient system to be able to settle cases. This requires medical-legal reports which address **all of the necessary**, complex issues in terms of precedent legal cases as substantial evidence.

As is the reality with all professionals, but, in this case, particularly doctors, they are only able to consider these complexities when working under a fee schedule which fairly

compensates them and acknowledges their expertise by paying on an hourly basis. The Workers' Compensation system cannot operate with any assumption that the doctors, who are signing under penalty of perjury, are not to be trusted or believed.

I am extremely concerned that medical specialists, doctors who are counted upon to provide comprehensive reports that I am able to use as evidence (particularly psychiatrists and psychologists), will no longer be a part of the QME system.

Whereas I understand that more (not fewer) AMEs and QMEs are needed to serve the Workers' Compensation system in the State of California, the current fee schedule, if implemented as proposed, would have dire consequences in that regard.

Daniel C. Schainholz, MD, MPH, QME (OPH) July 8, 2020

The proposed changes to the DWC Medical Legal Fee Schedule demonstrate a tragic misunderstanding of the process of the QME or AME. A flat fee for a comprehensive report and a flat fee for medical record review suggests that the process is essentially equivalent across all specialties and cases. Nothing could be further from the truth for the specialty of ophthalmology, which must include the evaluation of no fewer than sixteen (16) parameters to properly evaluate an individual, with consideration of other systems and chapters. While a special modifier exists for psychiatry, psychology, toxicology and oncology, no such special modifier exists for ophthalmology. It is a complete misunderstanding on the part of the DWC to think that the full spectrum of eye disease is on a par with low back pain.

The proposed changes are a thinly veiled attempt by the insurance industry, which is making record profits, to delay, reduce or deny valid claims. The DWC is threatening to smash the jewel in the crown, its specialist QME report writers. Such discounts are impermissible under LC139.2(o) since they would bias the report writer. These proposed changes to the MLFS have a strong potential to bias the report writers against the Defendants. More importantly such flat fees will promote mediocrity in the reports.

The DWC must be cognizant of the fact that the QME/AME is the very last line of defense against the intrinsic bias within workers' compensation, which is to view all symptoms through the lens of work-relatedness. The QME is the only physician in the process provided the opportunity to take a fresh look and identify patterns that might reflect an unrelated syndrome or overlooked manifestations of disease. The flexibility based upon trust of the QME to properly review medical records, examine the injured worker, in as much depth as is medically indicated, and synthesize the information in a clear report with references for unusual conditions, is critical to the health and well-being of the injured worker, and ought to be reimbursed with respect to the

extraordinary complexity of such cases. A flat fee is a disservice to the injured worker, and disenfranchises the report writers by encouraging bad medicine. The conglomerates and the insurance companies are the winners, and the applicants and independent report writers are the big losers with the proposed MLFS changes. Please consider the damage the DWC will do by acquiescing to the underwriters' demands. The changes, simply put, are anti-academic, in a field which demands scientific rigor.

The time it takes to write a report is variable, and flat fees should not be imposed upon the report writers, especially given that the attorneys have the luxury of commission-based compensation. From the "30,000 foot view" the injustice is staggering. Rather than promoting a better system, these changes have the potential to create irreparable damage.

From my point of view, the fault for the increasing costs of medical record review lie in the DWC's failure to keep up with technology. If the DWC were to create a cloud-based, fully password protected and encrypted system, to maintain and distribute medical records electronically, duplicates, as well as paper and mailing costs, could be reduced. The DWC is well poised to require the EHR providers to generate specific summary reports, like current and past medication lists, past surgical history and so forth in a convenient copy and paste format. The prevention of redundancy is a better way to control costs than simply disenfranchising the report writers.

The DWC should be advocating for its report writers, not allying with the underwriters to damage the system. The insurance companies have their own advocates. It ought to be the DWC's fiduciary responsibility to advocate for the report writers, since by providing the most optimal conditions for an unbiased comprehensive report, the Trier-of-Fact has the best opportunity to provide a fair and equitable judgement. Providing a simple cost-of-living adjustment to the base rates, that have not been updated since 2006, would be a far more palatable improvement of the MLFS. The system has always been based upon trust, and that trust is a critical underpinning of the process. A flat-fee is a manifestation of a perceived lack of trust, and the consequences of such a myopic change could be terrible for the injured workers and the report writers.

There is a saying in India that "the only form of blindness that cannot be rehabilitated is political blindness." The primary goal should be to improve the quality of reports, not demand mediocritization with a fee scale that is punitive to the reports of extraordinary complexity. The proposed MLFS changes are a capitualtion to the avarice of the insurance companies and do not support the report writers, without whom the system would not function at all. Please leave the hourly rate in place since all cases and all batches of medical records differ. The only common denominator is the time it takes to complete the reports. The DWC should be advocating for improved reimbursement and fewer excuses for the insurance companies to deny, delay or reduce valid claims.

The system depends upon the DWC making a sound judgement that does not undercut the single most important aspect of the system that is intended to benefit the health and well-being of the injured worker. The DWC must not disenfranchise the report writers. Disincentivizing best-practices in favor of optimizing shareholder profits would be a tragic mistake with foreseeable consequences. Report writers need to be held to a higher standard and properly compensated for the trusted position held in the medical-legal system.

S. Gary McClure, Ph.D., ABMP July 8, 2020

The DWC proposed changes to the QME Fee schedule are perplexing. It is my understanding that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months and the parties reached agreement on many of the fee change issues.

However, the DWC subsequently modified the agreed upon terms reached by the stakeholders, substantially reducing QME reimbursement. Instead of acting as an umpire, calling balls and strikes, DWC appears to have confounded its role, and has become an active participant in the stakeholder negotiations. This causes me to question, who does DWC represent? Can DWC explain why the agreed upon stakeholder plan was not adopted?

The agreed upon terms reached by the stakeholders was based in part on the DWC audit that recommended a 30% increase in QME fees. The DWC current QME proposal reduces fees for many of the QME services provided, such as complex med/legal evaluations.

Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Not only did her proposal modernize reimbursement for QMEs, but it also addressed most of the issues raised by the stakeholders.

I support Sue Honor's proposal which the QME community has already broadly supported and is more closely aligned with the stakeholder agreed upon plan. The current DWC proposal does not address the issues raised in the DWC audit (30% increase in QME fees), but rather the current DWC proposal decreases many of the fees for QME evaluations.

Peter J. Sofia MD July 8, 2020

As an orthopedic surgeon, the new proposal is reasonable, if not ideal in some areas. Generally, though, I support it.

Jonathan M. Frank, MD
Orthopaedic Surgeon, Sports Medicine and
Joint Preservation Specialist

Team Physician, US Ski and Snowboard Associations

July 7, 2020

I am QME and I have learned that provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by the DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I **am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process**. Unfortunately (but not surprisingly given DWC's demonstrated track record of bias towards insurance company interests and against injured workers and medical providers), **DWC violated the stakeholder agreements in order to favor the insurance carriers.**

Specifically, DWC made the following changes against the stakeholders' wishes:

	DWC Stakeholder Meetings	**California DWC Proposal**
Reimbursement per page	$3 (starting on page 201)	$3.00 (pages 201 – 2000) **$2.00 (pages 2001+)**
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Definition of re-evaluation	9 or 12 months	**24 months**
AME Modifier	1.25x and applies to **all services**	1.35x but applies **only to flat fee and not to depositions**
Medical records required to be sent 15	Yes	**No**

	DWC Stakeholder Meetings	California DWC Proposal
days prior to evaluation		
Cover letter required to specify number of pages sent to doctor?	Yes	**No**
Automatic Annual COLA Increase?	DWC refused to hear this issue in the stakeholder meetings	**No**

DWC should modify the fee schedule in the following specific ways:

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- Pages should not be legal sized, only standard sized
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- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- <u>The mental health modifier should be increased to 3.0x</u>

- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)

- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report

- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.

- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Shirley Gyepes, Director — July 7, 2020
Atrium Services, Inc.

Our company has provided QME practice management since 2004.

The proposed changes to the QME fee schedule are **unacceptable**. It severely underpays QME doctors, and will hurt injured workers - the very population the DWC is responsible for protecting.

The current plan aligns with insurance company financial goals, and not the best treatment or interest of the injured worker. Stakeholder meetings were held - to wisely bring all voices to the table. Insurance company recommendations are the only ones reflected in this proposed fee schedule. The goodwill created between QMEs and the DWC during the stakeholder meetings was erased once the DWC released this proposed fee schedule.

Doctors performing QME evaluations impact the course of injured workers' lives. The highest attention should be paid to what is best for the injured worker. Inadequately paying QMEs discourages talented doctors from remaining or becoming QMEs. This fee schedule LOWERS compensation to the doctor. There has not been an increase in QME compensation since 2006. Nothing. Nada. Zip. Not even COLA.

DWC literally means Division of **WORKERS**' Compensation. Its stated mission is "...to minimize the adverse impact of work-related injuries on California employees and employers."

This fee schedule will only harm Californians - the injured worker, and the QME.

The DWC should

1) Modify the fee schedule to:

- All pages over 200 should be reimbursed at $3/page
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- The mental health modifier should be increased to 3.0x

OR

2) Adopt Sue Honor's proposal, the former manager of the DWC Medical Unit. She submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

Sue Honor's proposal and the accompanying petition can be found here:
https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

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Medical Legal Fee Schedule Forum Comments

David E. Sones, MD July 7, 2020

This proposal to alter the regulations for the Medical-Legal Fee Schedule represents a major change from the current policy. These new regulations are ambiguous and will lead to increased friction between the providers and payors. I believe they need to be completely revised.

I along with most other physicians have major objections to the proposed changes. A fixed fee is entirely unacceptable. The changes will do nothing to stem the tide of Qualified Medical Examiners leaving the system, leading to only further delays in the delivery of benefits to injured workers.

As a psychiatrist, virtually all of my initial examinations are billed at ML104 due to the additional complexity factor for this type of exam. While many who have traditionally billed at ML102 and ML103 will see an increase in reimbursement, even with the multiplier for psychiatry this proposal will result in a drastic cut in pay for me and all the physicians in my specialty. I had anticipated that since there had been no change to the rate of reimbursement since 2006, any new fee schedule would actually lead to an increase in pay.

One proposed solution is that that for more complex cases, the fee should be negotiated. However, this suggestion is completely impractical. I never know how long it will take an exam to complete in advance. What may seem to be a simple case based upon materials sent prior to the exam can often become extremely complicated due to important events at work-- extensive sexual harassment, repeated threats of violence-- that cannot be ignored. There may also be traumatic circumstances in childhood and adult life that have to considered. Add to that a poor informant or an interpreter who is unable to discharge their duties well, and the exam can take several hours to complete. The more complex the exam, the more time it takes to prepare the report.

Paying a flat fee will incentivize examiners to complete examinations hastily, leading to failures to recognize critical aspects of the history that might bear on factors of causation and apportionment. This will result in the need to further develop the record with a possible second examination. Under many circumstances, the parties my decide not to return to the initial examiner who failed to provide a report that was based on substantial medical evidence. This will restart the entire medical-legal process with a new examiner. In either case, this will result in increased costs that easily could have been avoided if examiners were properly reimbursed for their time and expertise.

To remedy this flaw in the proposed fee schedule, the only reasonable solution is the one in Suzanne Honor's proposal: an additional fee for every 15 minutes of face-to-face time in excess of the first two hours. It is simple and reasonable, resulting in more fair and frictionless reimbursement. I have been informed that the Division would not even consider this proposal, but no logical explanation has ever been offered to not adopt this suggestion.

If the Division is unwilling to consider the sensible approach to reimbursement for complex exams as proposed by Ms. Honor, then the only alternative is a modifier for psychiatric evaluations. However, the modifier of 1.5 is completely unacceptable. This modifier will not come close to compensating a psychiatrist for the total time spent on 200 pages of record review, face to face time, and report preparation time. Instead, if the Division is going to insist on a flat rate, the modifier should be at least 3 times higher than the standard fee.

The proposal has changed the reimbursement for Agreed Medical Examiners. Under the current schedule, all services provided by an Agreed Medical Examiner, including evaluations, preparation of supplemental reports and medical testimony, are reimbursed at a higher rate. This has been accepted by all stakeholders because the extra costs are more than offset by a reduction in frictional costs that might otherwise occur with less experienced examiners in complex cases. This proposal only provides a higher rate of reimbursement for comprehensive and follow-up medical-legal evaluations, and even in these situations excludes the additional charges for reviewing medical records in excess of 200 pages. The modifier should continue to be applied to all services in including the fee for review of additional medical records and missed appointments in recognition of the higher quality of work provided by Agreed Medical Examiners.

The proposal includes a reduction in the per page fee for review of medical records after 2,000 pages. There is no evidence that reviewing any page after 2,000 is any less of an effort than reviewing any of the first 2,000 pages. In fact, the opposite is likely to be true. Generally speaking, the more medical records, the more complex the case will be. Therefore, the fee should not change after 2,000 pages. Additionally, the burden of counting the pages is placed entirely on the medical examiner. This is likely to create unnecessary disputes about reimbursement. The insurers should be responsible for

providing an accurate count of all the pages and include a declaration under penalty of perjury. In the medical field, a standard page size is 8.5 by 11 inches. Legal sized pages should not be reimbursed at the same rate as standard size. Better yet, introduce a regulation that prohibits the use of any pages that are not standard size.

The current proposal indicates that physicians cannot be reimbursed for a supplemental report for records or sub rosa video that were provided to the physician prior to preparing or issuing a comprehensive medical-legal report or a follow-up medical-legal report. This is completely impractical. It would not be unusual to receive records well after the date of the evaluation. Imagine a situation when a physician receives 5,000 or more pages 28 days after the evaluation. It would be impossible to review all the records and incorporate them in a report before it was due on day 30. Under the proposal, the physician would be required to review all the records in a Remedial Supplemental Medical-Legal Evaluation without any compensation. I hope this is not the Division's intent. Assuming this is not the case, then the obvious remedy is to only disallow reimbursement for a supplemental report in cases when records were provided no later than 15 days prior to the examination date, as required by regulation.

As defined by the proposal, a Follow-up Medical-Legal Evaluation occurs within twenty-four months of the date on which a prior comprehensive medical-legal evaluation was performed. The 24 month period is much too long. There may have been multiple injuries and other stressful circumstances during the interim that will require extensive assessment. Instead, the current time period of 9 months should be maintained. Anything after 9 months should be considered another comprehensive exam.

The Division has not altered the fee schedule in 14 years even though they are mandated to review the fees every year. In the meantime, costs of living have been increasing, leading effectively to a reduction in reimbursement. To avoid this problem from recurring, there should be an automatic annual cost of living increase to the Schedule.

When I commented in a forum about a previous proposal for the medical legal fee schedule, I stated that I believe all the shortcomings can be resolved if the parties are willing to negotiate in good faith. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that the Division did not honor the terms that were agreed upon in the stakeholder process. I would not describe these actions to be in good faith. I hope that going forward that this approach no longer continues.

Due to its serious flaws, the proposed schedule should be completely discarded. Good faith efforts to develop a sensible fee schedule that all stakeholders, including providers, can agree to should be resumed. In the interim, until a new schedule can be created,

we should continue to rely on the current schedule, but with an immediate across the board increase of 30% on all fees to adjust for the increased costs of living since 2006.

Joshua Pretsky, MD, QME, AME
Distinguished Fellow, American Psychiatric Association
Associate Clinical Professor of Psychiatry
David Geffen School of Medicine at UCLA

July 7, 2020

I am writing to convey my serious concerns about the proposed MLFS revisions now being considered. As an academic psychiatrist and clinician educator I value and prioritize truth, fairness and the social good over opinion and self-serving special interests. From this perspective, I see a series of problems associated with the currently proposed revision of the MLFS. In an era of dwindling numbers of QME's, it baffles me that the DWC is taking steps to further alienate us. As a psychiatrist I am **especially** troubled by the effective massive cut in compensation for psych evals when there should be, on the contrary, a COLA increase from 2006. In the past I would advocate to my graduating psychiatry residents that work as a QME was rewarding and gratifying. With the currently proposed changes, I could not, in good conscience, encourage them to pursue this line of work. What have you done to address the reduction in QMEs based on the 2019 audit? The kind of proposal now before us regarding the MLFS only serves to further drive physicians away from the worker's comp system.

As a CSIMS member, I have carefully reviewed and considered the below recommended alterations to the current MLFS proposal and fully concur with them:

- All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an **automatic annual COLA increase for QMEs**. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- **The mental health modifier should be increased to 3.0x (Psych exams are exceedingly complex, face-to-face interviews alone typically take 4-5 hours**

and multiple complex factors, such as childhood events and vulnerabilities, must routinely be assessed and considered in causation and apportionment)

- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)
- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report
- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.
- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.
- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier

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Susan C. Rose, Ph.D. July 7, 2020
Qualified Medical Evaluator
Licensed Psychologist

After reviewing the recently Proposed Medical-Legal Fee Schedule and speaking to mental health colleagues about these, I have decided to write a letter and spend a little time trying to provide context for our objections to the proposal. Hopefully, this will be read, considered and helpful in sorting out the final fee schedule as the stakes for the workers and employers of this state are substantial if we do not create a quality process of evaluation, which is right, fair and equitable.

As I look at the details of the proposal, it is of interest to me how the reasons for the specific item changes appear to be lacking and all QMEs of all specialties are treated as though we are being asked to do the same thing in these evaluations; the only variation being amount of time spent with the individual and reviewing tests and records, which is mildly noted in the modifier for psych being 1.5. This strikes me as inherently unfair and indicates an ignorance of how assessments are done by different specialties or else a failure to utilize this knowledge, to the detriment of the psychiatric evaluations, which are often the most complex.

When years ago, I began this Psychiatric QME work, the only requirement was that the AOE/COE causative factor consist of a small amount, 10%, of all potential factors, literally taking the employee as he was found. However, in order to more fairly determine an employer's responsibility for causing a psychiatric injury to an employee, categories of predominant, substantial and contributory factors became the standard. As the clinician was asked to determine the proportion of these possible industrial and non-industrial factors in the causation of any psychiatric injury, this required us to conduct a longer and more thorough evaluative interview to obtain a detailed account of these factors.

In the past, when only a small percentage of causation was needed to establish the existence of a compensable injury, a more cursory background history could be obtained in less time and still provide enough information to determine opinions based on substantial medical/psychological evidence and reasonable medical probability. As well records provided could be scanned more quickly and yet fairly be considered in the formation of opinions of psychiatric injury.

However, when the categories of predominant, substantial and contributory factors became the assessment standard, significantly more time was needed to obtain a full occupational history sometimes covering an entire career of more than 30+ years, which might include multiple injuries with various treatment components with positive and negative outcomes. Also, a full history of a claimant's entire personal life beginning from birth with significant investigation of details related to family background, education, social life, mental and physical health, and traumatic experiences, became necessary to determine non-industrial factors to determine the contributions of any of these to causative factors for development of a psychiatric injury. Not only was the evaluative interview necessarily longer and more involved (typically 3-4 hours), but the information

provided needed to be well integrated and understood within the context of complex psychological functioning and dynamics based on clinical research in addition to medical records and a statistically significant and complex psychological test battery. This increasingly more complicated assessment process became more time consuming as clinicians considered more information obtained in terms of what is known about psychological functioning of the mind and body within social systems over time; and for the additional purposes of determining credibility and potential for malingering with more specificity.

As the Worker's Compensation system has attempted to become a fairer process over time, holding employers only responsible for a very specific portion of the causative factors of injury, the Rolda analysis often became the standard in the assessment process for psychiatric injuries. This required the clinician to very carefully investigate with the applicant at the time of the interview any causative factors that would have a bearing on the development of a clinically significant disorder such that percentages of industrial and non-industrial causative factors could be parsed and justified with well-founded explanations as to these determinations. Also, the medical records provided to clinicians subsequently were often therefore more substantial and comprehensive and had to be gone over with a fine-tooth comb in order to produce a report with opinions based on substantial medical/psychological evidence and reasonable medical probability.The process of comparing different accounts in order to assess credibility, a reasonable understanding of what had happened during an applicant's career and personal life currently and in the past, and reliable and valid psychological symptoms, patterns and dynamics, and test data, has become very time consuming and yet no less important in being accurate and fair. I cannot tell you how often the attorneys in a deposition become focused on one small detail in order to determine the validity of some opinions, which is an appropriate focus. However, this requires the clinician to be very attentive to details regardless of the massive amount of information gathered, which go into the opinion determinations.

And since the need for psychiatric opinions in many of the straightforward orthopedic cases has decreased as the law has changed, the types of cases that I and colleagues are being asked to weigh in on are typically more complex and often come with more substantial numbers of medical records for review, than in the past.

When I think of all that is required of me and goes into the production of my opinions and reports, reading the Proposed Medical-Legal Fee Schedule, now under consideration, is disturbing and seems very unfair in many ways to the assessment work I do for the Worker's Compensation System.

First of all, the overall fees suggested are inadequate to the demands made of the psychiatrists and psychologists in the performance of their assessments of workers who have sustained psychiatric injuries allegedly industrially related. Every year, as this

assessment process becomes more demanding and detailed with more records to review and incorporate into opinions and reports, which I have stated is much more time-consuming, it becomes less cost effective to remain a QME. When fee schedules are as low as has been proposed, I can anticipate a reduction in qualified QMEs willing to perform these important jobs over time. Then when I look at the suggestions that examiners should be paid $1 less per page to review and incorporate more medical records, i.e., more than 1800 pages, it becomes more ridiculous and unfair as from what I have argued above, more records increases the tasks of integration, comparison and detailed scrutiny required in today's psych cases.

I was further dismayed when I read that clinicians would be penalized by being required to produce a free supplemental report related to record review, in situations wherein the attorneys fail to provide records in a timely fashion. It is already difficult to perform my job well when records are not available prior to or even as late as the day of my interview with the claimant. I am at a serious disadvantage in being able to do a reasonable job for all parties wanting me to fairly determine AOE/COE causative factors with specificity, per Rolda. If these records come late in my assessment process, given the 30-day deadline requirement for the completion of reports, there is no way that they can be appropriately read, digested and integrated into my opinions and report. When records arrive too late for a fair consideration before the report is completed, i.e., before or on the day the applicant is seen, they can only be fairly considered in a supplemental report, which even then is less than an ideal process as there is no chance to ask the applicant about material within the records until a possible reevaluation examination, if not delineated by the attorneys in a cover letter prior to the examination. But to think that on top of this problem, I would be further penalized by no fee for additional work in the form of a supplemental report and review of all opinions produced, is unreasonable. As well, without any pressure for the insurance company attorneys to provide the clinician with records on time as needed to perform the assessment fairly and reasonably, I will expect that this delay in records with an unpaid second supplemental report will become the norm, further reducing the amount of compensation for such evaluations and becoming another deterrent for mental health clinicians to do this type of work.

In keeping with what I have stated thus far, it seems unreasonable that the psych modifier, which has been proposed, would be 1.5. I am in agreement with others who have indicated that a fairer modifier for psychiatric cases be 3. However, another way to compensate mental health professionals fairly for this work would be to make the modifier 2.5, but with a caveat of additional modifiers of .5 for a Rolda analysis and .5 for a prior history of psychiatric difficulties, including past psychiatric claims, which significantly increase the workload of a case.

Also, it makes sense to me that the final version of the fee schedule would include a COLA, which has thus far been left out.

In conclusion, I hope you will reconsider the Proposed Fee Schedule under consideration as it fails to adequately compensate mental health professionals as it is written to date for the complex and increasingly more demanding job that we have been required to do every year.

Thank you for your consideration of this letter.

Stephen J. Heckman, Ph.D., QME
Licensed Clinical Psychologist
Qualified Medical Evaluator

July 7, 2020

I wish to address a number of issues regarding the proposed new fee schedule for QMEs under §9795. I have practiced as a Licensed Clinical Psychologist in the State of California for 37 years, since 1983, and have been a Qualified Medical Evaluator for 22 years, since 1998.

First, there are serious problems with having a “one-size-fits-all” flat fee for medical-legal evaluations. It is erroneous to consider the complexity of a psychiatric QME evaluation as equivalent to a medical QME evaluation, and *implementation of a flat fee appears to reflect a lack of understanding of this difference*. Many stress claims involve cumulative stressors that have occurred over the course of years. Consequently, many claimants will present with numerous incidents and issues which they describe in considerable detail—and which is necessary for the QME to listen to, in order to arrive at a clear understanding of what transpired at the workplace. For example, in a recent QME evaluation performed by this examiner, a law enforcement officer presented with issues which he found stressful on the job, and which culminated in his filing his workers’ compensation claim. Due to repetitiousness, I was able to condense 41 complaints down to 29 issues which had occurred over the past 3 years. I was asked by the claims administrator to apportion percentages of causation to each of these 29 different stressors—which I hope you can imagine, required considerable analysis and reflection, as well as time spent doing so. In another case, the applicant had filed 3 previous stress claims with past employers over the course of approximately 17 years, and in performing my evaluation of the current stressors claimed, it was necessary to review, interpret, analyze, and come to conclusions regarding each of these 3 prior stress claims, at least 2 of which involved multiple extremely detailed QME psychiatric evaluations, reevaluation reports, and psychometric testing. Again, all of this took considerable time to write up in a coherent report.

Furthermore, particularly in stress cases in which applicants are experiencing severe anxiety, conducting a clinical interview is often extremely challenging. Many patients are highly agitated by having to recount the circumstances of their work injuries, and due to

this education, often exhibit great difficulty relating a clear, chronological narrative regarding events in the workplace; to the contrary, their presentations often are quite jumbled, and involve telescoping back and forth in time between different incidents, requiring repeated frequent redirection by the QME to get them to focus again. Given the typical complexity of many of these cases, it is not unusual for the clinical interview to take anywhere between 3 ½-5 hours to make sense of numerous stressors which the individual is attempting to describe. ***This is certainly quite different from what an orthopedic QME would be faced with in terms of assessing a patient's leg or back—and is far more complex. Therefore, implementing a flat fee—in which "one-size-fits-all" seems most inappropriate.*** Would you call up your local car dealership and say: *Send me over "a car*"? Not likely, as if you are 6 foot 4, you would probably not want to ride in a subcompact vehicle; conversely, if you were 5 foot 2, you would probably not want to ride in a full-size van. You also wouldn't call Macy's, and ask them to send over "*some clothes*." You would want to try them on to make sure they fit your particular body type. My point being that not all evaluations are equal to other evaluations in complexity.

There are also problems with the new fee schedule reimbursing a certain dollar amount for a certain number of pages reviewed. The regulations refer to "the first 200 pages." As pages of records vary tremendously in complexity—from pages and pages of lab reports or nurses' vital readings, hospitalization—which can be quickly leafed through for a psychiatric exam— to highly, sometimes excruciatingly detailed psychometric findings and narrative reports. Once again, this application of "one-size-fits-all" is completely oblivious to the tremendous variation in complexity that QMEs deal with. Furthermore, offering a flat rate of $650 for a Supplemental report, once again applying "one-size-fits-all" who else to take into consideration the fact that a supplemental report can involve something as simple as a one paragraph clarification of a statement from a previous report—or it can involve as many as 25 or 30 pages of written report make revisions and conclusions about causation, apportionment, treatment needs, etc. based upon the records or new surveillance information which may contradict conclusions based on previously-available information.

I understand that workers' compensation carriers wish to reduce their costs. However, implementing a "one-size-fits-all" model would serve to discourage those QMEs who are dedicated, and who take their time in careful thought and analysis, by making it no longer cost-effective—and in fact would, without perhaps realizing it, reward shoddy and slipshod work instead.

Here is 1 way in which carriers can save costs —*without the QME being punished by this disincentive program*

In the case of reevaluations, it would behoove the industrial carrier to ascertain if treatment previously recommended by a QME in initial evaluation *had actually been*

undertaken, as well as ascertain if the type and duration of such treatment were in fact undertaken and/or completed. I cannot tell you how many times I have been asked to perform a reevaluation only to learn during the clinical interview that despite the elapsing of 6-8 months, the claimant had only just begun psychotherapeutic treatment 2 months prior to the reevaluation, and was still quite far from being Permanent & Stationary. In such cases it has fallen upon me to indicate that the patient is in fact not yet Permanent & Stationary, as treatment has just begun to be implemented—which will necessitate another reevaluation down the line. If workers' compensation carriers would really like to save money, I am guessing that it would take anywhere between a few minutes to possibly ½ hour to determine how far treatment has progressed; if the treatment was only begun recently, then it would make much more sense to perform a reevaluation at around the time when treatment would be completed. This would save the industrial carriers thousands of dollars in unnecessary/premature reevaluations.

Shane P. Hutton, PhD, QME July 7, 2020
Clinical Neuropsychologist

I am very disappointed in the proposed changes. As the pendulum swings often in the Workers Compensation System, I see this as a pendulum swing to far that suggests collusion with insurance companies. I believe the DWC's intent to save money however, would not go on deaf ears to many of my colleagues.

In the past, there was corruption found among a very small minority of physicians in the WC system. Rightly many of these physicians have been subjected to the appropriate discipline. Each discipline (including physicians, insurance companies and the DWC proper) have its own code of conduct – none-the-less; in each there are some (the minority) who take advantage of billing for their own personal gain (To follow the easy and familiar paths of personal ambition and financial success).

This self-serving attitude merely creates difficulties for the injured worker. The Workers Compensation System is the "exclusive remedy" in CA. I believe we should all be Proud to stand behind these statutes and set an example for all States who lack such judicial balance.

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

I will not reiterate Sue Honor's proposals as my colleagues have made it clear already.

On a personal note, I have chosen some offices in underserved-remote areas. Given that office's and gas prices will not change I will likely close these offices given the proposed established QME fee.

Eric Levander, M.D.,M.P.H., Q.M.E., D.F.A.P.A. July 7, 2020

I am a psychiatrist who has been a QME for the past few years. I find the proposed changes to be unacceptable. If enacted, this fee schedule will increase the administrative burden on QMEs, not compensate them fairly, and undoubtedly reduce the already record-low number of QMEs still left in the system.

Here are several problems with the proposed regulations:

- **Report More Complicated? You Must Give the Carriers a Discount:** The current fee schedule allows for QMEs to bill for their time when billing under ML-104. Under the current proposal, if you get a lengthy set of records to review, then you can only bill $2/page after the first 1,000 pages.
- **Medical Research Goes Uncompensated:** You will no longer be reimbursed for time spent performing medical research.
- **Extra Face to Face Time Goes Uncompensated:** If you have a complex history you need to take then you will not get to bill for your time. Everything under the new fee schedule is under a flat fee
- **You are Responsible for Keeping Track of All the Medical Records, Not the Insurance Carriers:** Under the proposed regulations, none of the parties including large insurance carriers will have to tell you the number of pages you are being sent. The burden is solely on the QME to accurately count the number of pages you have received and bill accordingly. Expect this to create more friction, payment denials, and litigation as QMEs fight with insurers over how many pages were *actually* sent and received.
- **Work for Free or Get Disciplined:** Under the proposed changes, there are circumstances in which you would be obligated to provide supplemental reports

for free. This includes a situation in which you didn't address an issue that any party thinks you "should have addressed." If you decline to work for free by issuing a so-called "Remedial Supplemental Medical-Legal Evaluation" then the "Administrative Director or his or her designee" will have grounds to discipline you. In contrast, there are no new rules to hold insurance carriers accountable for anything.

- **Cost of Living Increase – Denied!:** The heart of the current controversy on the fee schedule is that DWC has not increased fees for QMEs in 14 years. We have consistently urged DWC to include an automatic annual COLA increase to the fee schedule, but they have refused. This glaring omission guarantees that the QME fee schedule will remain an ongoing issue for years to come

- **QME Crisis:** If you are reading this, chances are that you are one of the few remaining QMEs in the system. The number of QMEs continues to plummet to all-time lows while the demand for their services is at an all-time high. We had hopes that a new fee schedule would compensate you reasonably (or at least as much as a doctor in Nevada!). It is important that you make yourself heard and tell DWC how these changes will affect your participation in the QME program.

DWC has intentionally NOT applied the psych multiplier to record review. This makes no sense. Reviewing medical records from a mental health perspective is inherently more time-consuming and complex than reviewing medical records for a non-psych specialist. Furthermore, I have found that often valuable information is obtained from a careful and thorough review of such records. I urge DWC to increase the multiplier to at least 2.0x **and** apply the psych multiplier to record review fees, not just the flat fee.

In December 2018, Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders. The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is truly demoralizing and disheartening.

Insurance companies demand that their premiums be paid, or you lose your insurance coverage. Attorneys expect to be paid for their part of the workers compensation process or they take you to court. Judges certainly expect to be compensated for their work. Court reporters and interpreters expect to be paid, even for missed appointments! So how is it reasonable for the med-legal fee schedule to allow for a loop-hole that will cost the qualified medical examiner hours of extra time and yet not compensate them.

At a minimum, DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at least $3/page

- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- The mental health modifier should be increased to 3.0x
- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)
- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report
- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this prior to performing the service. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC

should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.

- Neurology, Oncology, Toxicology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

In my opinion, if this fee schedule is implemented, it would result in a catastrophic deterioration in report quality, especially psychiatric and psychological reports (and probably reports in other fields). A review of the DWC's own suggestions for what is required for an adequate report ("Method of Measurement of Psychiatric Disability") makes it clear that the work required to produce a psychological/psychiatric report that can meet the criteria for substantial medical evidence would not be adequately compensated if this proposal is adopted. With the elimination of complexity factors for causation, apportionment, and research, psychiatrists and psychologists would be faced with the choice of producing hastily written, substandard reports, working many hours without compensation, or exiting the system.

This proposal will be the final straw for many providers, including myself.

I urge DWC to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

W. Timothy Brox, MD July 7, 2020
QME, Orthopaedic Surgeon, FAOA

I am grateful that some progress is being made towards an improved California Worker's Compensation ML Fee Schedule.

It was my understanding that DWC hosted stakeholder meetings occurred between insurance payors and QMEs over the past several months. I also understood that fair and equitable changes for ALL QME specialists were discussed and terms were agreed upon. As I understand, this fee schedule undercuts what was agreed at the Stakeholder Meetings.

The proposed fee schedule has several important flaws, for me Points 1 & 2 are the most critical, but I make these observations:

1. A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months

2. The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this prior to performing the service. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

3. All pages over 200 should be reimbursed at $3/page

4. Pages should not be legal sized, only standard sized

5. The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.

6. The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i). Last, if the scheduled evaluation does not occur because the worker’s request to record the encounter is declined by the QME, these would all constitute a missed appointment.

7. The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report

I request that these improvements be made to the posted new ML fee schedule.

Victoria Kuhl, Ph.D. July 7, 2020
Licensed Psychologist
California Qualified Medical Evaluator

I am a psychologist who has performed QME and AME evaluations in my field since 2010. I would like to offer my comments on the proposed changes to the billing regulations. In my opinion, if this fee schedule is implemented, it would result in a catastrophic deterioration in report quality, especially psychiatric and psychological reports (and probably reports in other fields). A review of the DWC's own suggestions for what is required for an adequate report ("Method of Measurement of Psychiatric Disability") makes it clear that the work required to produce a psychological/psychiatric report that can meet the criteria for substantial medical evidence would not be adequately compensated if this proposal is adopted. With the elimination of complexity factors for causation, apportionment, and research, psychiatrists and psychologists would be faced with the choice of producing hastily written, substandard reports, working many hours without compensation, or exiting the system.

Templated, prefabricated reports devoid of the necessary careful analysis of the relevant data would do nothing to assist the parties in resolving cases. It would be impossible for any evaluator to adequately address the many complexities involved in a psychological/psychiatric evaluation at these rates of reimbursement. Many of us, myself included, would find it unethical to produce substandard reports. Given the fact that few of us can afford to work for free, implementation of the proposed fee schedule would undoubtedly force competent, ethical evaluators out of the system.

This proposal contains a clause that would force QMEs to review 200 pages of records without compensation beyond the flat fee, and the psych multiplier would not be applied to record review. The pay rate that is proposed for record review after 2,000 pages is less than the rate for pages 201 to 1999. This, and the flat fee, would mean that the QME would make less and less money, the more he or she works on a complicated case. One would think that all stakeholders, including defense counsel and insurers, would want QMEs to fully consider all factors affecting a claimant, including all non-industrial sources of stress. The proposed fee schedule would make this impossible without necessitating pro bono work. With this fee schedule, QMEs would be incentivized to spend a minimal amount of time with claimants and produce reports as

quickly as possible. Any cost savings to the system would be negated by the decline in report quality, resulting in an increased need for depositions and supplementals to clarify hastily written opinions.

This is not the first time that DWC has proposed to slash QME reimbursement despite recommendations by Sue Honor, and despite general reimbursement agreements reached between insurers and QMEs in the recent stakeholder meetings. It again appears that someone in authority at DWC has an incomplete understanding of the time and effort that it takes to perform an adequate QME evaluation, especially in the mental health field. Several aspects of the proposed fee schedule, such as the proposed "remedial" supplemental reports, suggest a disrespectful and punitive attitude towards QMEs. Everyone involved in the system benefits from admissible reports that can be relied upon by the parties to help resolve a claim. This proposed fee schedule will actively discourage the quality reports that the system requires to settle cases with a minimal amount of expense and friction.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported

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David Green PhD July 7, 2020

Having performed 100s of psychiatric/psychological worker compensation evaluations over the prior 3 decades, its my observation that the analytical burden in formulating causation and apportionment has not gotten any easier. The following tasks should not have an hourly limit to complete: 1.The culling of medical records to determine whether chronic pain/ distress is structural vs stress related, 2. the gathering of developmental psychiatric information or purposes of determining apportionment, and 3.the research necessary to determine what are the current cases and legal principles the formulation of psychiatric causation.

I am in agreement with the recommendations of CSIMS position on necessary revisions to the proposed DWC fee schedule:

1. a page of records must be defined as double spaced, single sided, 12 point or greater font, 81/2' by 11' with no condensed deposition transcripts
2. The party that submits medical records must list the records provided and attest to the number of pages under penalty of perjury. Page counts must include cover letters and any and all documents provided. Records should be submitted electronically and every page in the file counted. Records received less than 15 days prior to the date of the evaluation may be submitted as a supplemental report.

3. The fee for reviewing a page of medical records should be $3 regardless of how many pages are submitted and regardless of the type of report requested
4. A re-evaluation is an exam requested within11 months of a prior exam and where the applicant is available for evaluation within 60 days after the request. If these conditions are not met, then it is a new evaluation
5. The AME modifier should apply to all fees and all services. This includes medical record review, supplemental reports, depositions and examinations.
6. The psychology/psychiatry modifier should be at least 3x
7. Internal medicine, neurology, and pain medicine modifiers should be at least 2.0x
8. The 1.5 modifier for toxicology and oncology should apply to all reports for which toxicology or oncology is the primary focus.
9. Any physician requested to perform research should be able to bill by the hour, the number of hours by agreement prior to preparing the report
10. The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable. The DWC should retitle this "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this prior to performing the service. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b) or failed to answer a specific non-hypothetical question not requiring research. Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.
11. An automatic annual COLA increase should be included in the fee schedule. We recommend using DWC's own metric of Statewide Average Weekly Wage as the basis for the automatic, self-executing COLA increase.

Mark McDonald, M.D., Q.M.E. July 7, 2020
Adult, Child, and Adolescent Psychiatry

I have been performing psychiatric QMEs since 2015: The proposed DWC fee schedule misses the mark in every way possible.

First, psychiatric interviews require substantially more time to complete than do interviews in other specialties. Report-writing time is extensive. Burdens include the need for comprehensive history-taking, Rolda analyses, and the incorporation of often dense, complex, and conflicting medical records. The fee multiplier should be increased well above 1.5 to 3.0 to account for these added requirements.

Second, proposed record review reimbursement is woefully inadequate. With the current proposal of $2 per page for records in excess of 1,800 pages (quite common for psychiatric evaluations), at the commonly accepted rate of review of 100 pages per hour, compensation would be equal to $200 per hour—LESS than the current fee schedule of $250 per hour. This is a pay cut, not a pay increase. All record review should be reimbursed at a rate of $3 per hour, from the first page.

Third, this proposal fails to address the need for doctors to receive all records prior to the evaluation, in order to perform a comprehensive history gathering. If we are expected to include a complete record review in the report, continuing to allow attorneys to submit records after the day of the evaluation will cause delays in the issuing of reports, leading to report denials and requests for new panels.

Fourth, the proposed 24-month allowance for re-evaluation is unreasonable and impractical. Given the volume of records and interval history necessary to review, the proposed re-evaluation rate is inadequate. The maximum time allowance between initial evaluation and re-evaluation should not exceed 12 months.

Fifth, why is there no cost of living adjustment (COLA)? Much of the current problem stems from the absence of a COLA now. Failing to incorporate a COLA in the current proposal will lead to a recurrence of the problem we are ostensibly trying to solve today.

There are many additional flaws in the fee schedule proposal, including the allowance given to insurance companies to unilaterally decide whether or not to offer compensation for supplemental reports, forcing the responsibility of record page-counting onto the QME, and the elimination of all payment for duplicate record sorting and review. Every one of these issues was addressed and resolved during the stakeholders meetings in 2018 and 2019, yet the DWC continues to cling to the failed and rejected proposals no one—other than the insurance companies—wants or needs. QMEs will lose, attorneys will lose, and applicants will lose. Lose lose lose is not a proposal I can or will support.

John Paul Beaudoin, Ph.D. July 7, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

Sue Honor's proposal and the accompanying petition can be found here: https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Gerald Markovitz, MD July 7, 2020

I have been a QME and a CSIMS member for many years. As you are well aware, the medical-legal fee schedule has not been updated also in many years. I have learned that CSIMS and other provider groups have met with DWC and payer groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payers and providers on

several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process. It appears that the DWC violated the stakeholder agreements in order to favor the insurance carriers.

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months; too much may change in a patient's health history in 2 years that a re-evaluation at such a distance in time would be like a new evaluation.
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation and sent in a method of the QME's preference such as an via electronic (CD, flash drive, etc.).
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by the QME because the injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)

- The cut-off date for QMEs to include records or a sub-rosa in a face-to-face evaluation report (rather than in a supplemental report) should be the date of the evaluation, not the date of issuance of the report

- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. The DWC should rename this to a "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse the QME for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this *prior to performing the service*. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. The DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. The DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payers or QMEs.

- Time spent on necessary medical research should be reimbursed on a time basis.

These updates are crucial to maintaining a system that is fair to all in order to achieve the mission of the workers' compensation system to take care of the injured worker.

Sheldon F. Bloch, MD, QME July 7, 2020

I am writing in my capacity as a psychiatric QME in response to the proposals for a new fee schedule which are unacceptable to me as a dedicated QME in Psychiatry. Psychiatry interviews are exceedingly complex and often require at least 3-4 hours of interview time and more additional time which could take additional hours to study the medical and psychiatric history of the applicant and understand the applicant's personal and medical history in the context of the applicant's current problems, history and illnesses and injury. The modifiers are NOT adequate to begin to compensate for the extensive time necessary for these evaluations, which often require reviews of hundreds if not thousands of pages of detailed medical and psychiatric history,

The proposed pay scales do not begin to compensate for the time and effort necessary to know the applicant, the applicant's medical and psychiatric history In the context of the current Injuries and Illnesses and understand the applicant's dynamics In the context of his or her history and emotional development.

I have many other objections to the additional fee schedules and the new fee proposals which will make it impossible for me to continue to do the work of a psychiatric QME which I have found very satisfying and have allowed me to evaluate and recommend needed treatment when indicated. I cannot, however, continue to do this work at a rate which Is lower than it is already without cost of living adjustments. This is simply unfair!

These proposals are completely unfair and take advantage of well-meaning QMEs who are dedicated to helping evaluate injured or ill workers.

They will make it impossible to continue this work.

Shivani Patel Escamilla, Psy.D., MHA July 7, 2020
Administrator, Lagos Crisis Residential Program Riverside County

The proposed changes are to the QME rate schedule are unacceptable. If enacted, this fee schedule will increase the administrative burden on QMEs, not compensate them fairly, and undoubtedly reduce the already record-low number of QMEs still left in the system.

DWC has intentionally NOT applied the psych multiplier to record review. This makes no sense. Reviewing medical records from a mental health perspective is inherently more time-consuming and complex than reviewing medical records for a non-psych specialist. Moreover, all of the client who I have completed QME assessments for have had significant mental health challenges and symptoms and I have thoroughly enjoyed providing this service. However, the work is cumbersome and laborious and in the midst of the COVID crisis, I am unsure that it is worth continuing to serve as a QME if the time, energy and effort expended to complete these evaluations are no longer worth it because of these changes. We need more qualified and compassionate QMEs – not less. Thus, I urge DWC to increase the multiplier to at least 2.0x **and** apply the psych multiplier to record review fees, not just the flat fee.

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also

contained many critical qualitative changes that would decrease friction for all stakeholders. Why has DWC ignored this widely supported proposal?

Sue Honor's proposal and the accompanying petition can be found here: https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

Further, the fact that DWC has disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement DWC proposes is far below Sue Honor's recommendation and even less than the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge DWC to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

James O'Brien, M.D. July 7, 2020

The remedial supplemental code is not workable. Often it is unclear from a cover letter what issues should have been addressed and with Benson apportionment you will have a mess because often the dates of claimed injury do not match the claimant's narrative and the factors of employment are defined differently. We are psychiatrists, not psychics and we can't read minds.

The biggest problem is that the COLA does not match actual inflation and does not match inflation going forward. Which will be substantial given the current stagflationary fundamentals and debt.

Ren Hong, Ph.D., QME July 6, 2020

I had an opportunity to review the fee proposal set forth for QMEs and have found the proposal to be woefully insufficient in compensating QMEs like myself. I've listed my responses below:

1. Psychological QME interviews and reports will not be adequately compensated by a 1.5 modifier. This will result in the attrition of psychologist QMEs like myself as this will not compensate the number of hours required at a competitive rate. The modifier needs to be at least 2.5 to 3.0, and, at the lower rate, should include additional modifiers for Rolda and any past psych claims. The psych modifier should apply not only to the base rate but also to record review as the content of the records is frequently more comprehensive including past psychiatric records amongst other personnel records.

2. The proposed fee schedule is suggesting $2 a page for records over 1800 pages. Reading over 1800 pages does not expedite my reading speed any more quickly. At the commonly accepted rate of 100 pages per hour, this works out to be $200 an hour, which is **LESS** than the current fee schedule rate of $250. This would be a pay cut rather than the described pay increase that this fee schedule calls itself. Instead, all pages need to be paid at $3 per page!

3. The time frames suggested in the proposed fee schedule related to records is completely nonsensical. There must be clear and reasonable limits on when records can be received. This would be in the best interest of the injured worker and the system. Anything submitted beyond the day of the evaluation should be considered a supplemental report.

4. A period of 24 months is too long to be considered a re-evaluation. The amount of records and interim information can be extensive, and the re-evaluation rate is inadequate for this. The span should be no more than a calendar year.

5. Any new fee schedule requires a clause that incorporates an automatic annual fee adjustment to keep rates current. This should be standard in whatever fee schedule is ultimately enacted.

Please make the appropriate changes so that quality QMEs continue to provide this valuable service.

Adam J. Stoller, MD July 6, 2020

I am in agreement with the recommendations of CSIMS position on necessary revisions to the proposed DWC fee schedule:

12. a page of records must be defined as double spaced, single sided, 12 point or greater font, 81/2’ by 11’ with no condensed deposition transcripts
13. The party that submits medical records must list the records provided and attest to the number of pages under penalty of perjury. Page counts must include cover letters and any and all documents provided. Records should be submitted

electronically and every page in the file counted. Records received less than 15 days prior to the date of the evaluation may be submitted as a supplemental report.

14. The fee for reviewing a page of medical records should be $3 regardless of how many pages are submitted and regardless of the type of report requested
15. A re-evaluation is an exam requested within11 months of a prior exam and where the applicant is available for evaluation within 60 days after the request. If these conditions are not met, then it is a new evaluation
16. The AME modifier should apply to all fees and all services. This includes medical record review, supplemental reports, depositions and examinations.
17. The psychology/psychiatry modifier should be at least 3x
18. Internal medicine, neurology, and pain medicine modifiers should be at least 2.0x
19. The 1.5 modifier for toxicology and oncology should apply to all reports for which toxicology or oncology is the primary focus.
20. Any physician requested to perform research should be able to bill by the hour, the number of hours by agreement prior to preparing the report
21. The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable. The DWC should retitle this "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this prior to performing the service. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b) or failed to answer a specific non-hypothetical question not requiring research. Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.
22. An automatic annual COLA increase should be included in the fee schedule. We recommend using DWC’s own metric of Statewide Average Weekly Wage as the basis for the automatic, self-executing COLA increase.

Doug Grant July 6, 2020

I support he CSIMS position on necessary revisions to the DWC fee schedule proposal as follows:

23. a page of records must be defined as double spaced, single sided, 12 point or greater font, 81/2’ by 11’ with no condensed deposition transcripts
24. The party that submits medical records must list the records provided and attest to the number of pages under penalty of perjury. Page counts must include cover letters and any and all documents provided. Records should be submitted electronically and every page in the file counted. Records received less than 15 days prior to the date of the evaluation may be submitted as a supplemental report.
25. The fee for reviewing a page of medical records should be $3 regardless of how many pages are submitted and regardless of the type of report requested
26. A re-evaluation is an exam requested within11 months of a prior exam and where the applicant is available for evaluation within 60 days after the request. If these conditions are not met, then it is a new evaluation
27. The AME modifier should apply to all fees and all services. This includes medical record review, supplemental reports, depositions and examinations.
28. The psychology/psychiatry modifier should be at least 3x
29. Internal medicine, neurology, and pain medicine modifiers should be at least 2.0x
30. The 1.5 modifier for toxicology and oncology should apply to all reports for which toxicology or oncology is the primary focus.
31. Any physician requested to perform research should be able to bill by the hour, the number of hours by agreement prior to preparing the report
32. The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable. The DWC should retitle this "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this prior to performing the service. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b) or failed to answer a specific non-hypothetical question not requiring research. Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

33. An automatic annual COLA increase should be included in the fee schedule. We recommend using DWC's own metric of Statewide Average Weekly Wage as the basis for the automatic, self-executing COLA increase.

Kimberly Kaufman, Ph.D., QME July 6, 2020

I am hopeful that the DWC can come to a fair agreement for everyone involved with the new fee schedule. The most recent proposed fee schedule does not appear to be there yet.

I am a QME in the field of psychology and the fee schedule proposed by the DWC is very concerning to me and would likely make it unprofitable for me to continue as a QME. There are several points I would like to address.

First, A modifier of 1.5 is insufficient compensation for a QME in psychology. The psychological interview is much lengthier than other specialties and requires a gathering of extensive information which other specialties just are not required to gather. The reports are much more comprehensive and cover a much wider breadth and depth than any other specialty. Psychology is the only specialty that has a causation threshold of predominance requiring a more detailed report and discussion. Psychological reports also frequently require a lengthy discussion of personnel actions and a Rolda analysis, which takes further time. The proposed modifier should be no less than 3.0.

I am also confused that by the fee for record review? It somehow implies that records 1801 and beyond will take less time to review than the first 1800 pages. There should be a flat fee for all pages of $3.25 for all pages reviewed, which is consistent with the proposed new hourly rate of $325 an hour. There also needs to be clear stipulations for what constitutes one page of records.

Further, there must be clear and reasonable limits on when records can be received to be incorporated into the report. This would be in the best interest of the injured worker and the system. At the very least the cut off should be the day of the evaluation. Anything submitted beyond that should be considered a supplemental report.

In addition, the idea of a re-evaluation being extended to 24 months does not make sense. The rate of pay for re-evaluations tends to be lower than initial evaluations. Extending the time frame would require doctors to do the work of an initial evaluation for less money. The current fee schedule recognizes a nine-month cut off for re-evaluations. This being extended to 24 months is not acceptable. The longest it should be extended to is 12 months.

Finally, the DWC must add an automatic annual fee increase so that QMEs are not without a raise for several years as has occurred since the last fee schedule change.

I am urging the DWC to do the right thing so that we can continue to work in the best interests of both the injured workers and the payers.

Carla Scheel, D.C., QME July 6, 2020
CSIMS Member

The DWC held several stakeholder meetings with Physicians, Insurance Companies, and other industry constituents and what was agreed upon during those meeting is, unfortunately, not reflected in the current proposed changes. Furthermore, the Fee Schedule has not increased in 14 years to reflect the increasing costs that accompany running an office in which to perform examinations. Please consider the following revisions to the DWC fee schedule proposal:

1. a page of records must be defined as double spaced, single sided, 12 point or greater font, 81/2' by 11' with no condensed deposition transcripts
2. The party that submits medical records must list the records provided and attest to the number of pages under penalty of perjury. Page counts must include cover letters and any and all documents provided. Records should be submitted electronically and every page in the file counted. Records received less than 15 days prior to the date of the evaluation may be submitted as a supplemental report.
3. The fee for reviewing a page of medical records should be $3 regardless of how many pages are submitted and regardless of the type of report requested
4. A re-evaluation is an exam requested within11 months of a prior exam and where the applicant is available for evaluation within 60 days after the request. If these conditions are not met, then it is a new evaluation
5. The AME modifier should apply to all fees and all services. This includes medical record review, supplemental reports, depositions and examinations.
6. The psychology/psychiatry modifier should be at least 3x
7. Internal medicine, neurology, and pain medicine modifiers should be at least 2.0x
8. The 1.5 modifier for toxicology and oncology should apply to all reports for which toxicology or oncology is the primary focus.
9. Any physician requested to perform research should be able to bill by the hour, the number of hours by agreement prior to preparing the report

10. The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable. The DWC should retitle this "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this prior to performing the service. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b) or failed to answer a specific non-hypothetical question not requiring research. Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.
11. An automatic annual COLA increase should be included in the fee schedule. We recommend using DWC's own metric of Statewide Average Weekly Wage as the basis for the automatic, self-executing COLA increase.

Dr. B. Omrani July 6, 2020
Sylvan Medical Center

I am a QME in California since 2008. Did you know that the reimbursement rate for QME evaluations has not changed in the past 12 years that I have been a QME? I hope you realize how time consuming and tedious of a work it can be when the opposing parties ask you to determine cause of death, cancer, and complex internal conditions, including toxic (toxicology) cases. Aside from reviewing the records and speaking and examining the claimant, many of these internal medicine cases require hours of thinking, discussion, explanation, and research. As QMEs, we are not allowed to based our determination on facts that are no longer germane. For instance, if I am evaluating a case of exposure to a certain chemical that we did not know much about 15 years ago when I was in training, but know a lot more about now, I would have to spent hours evaluating the new knowledge and apply in to the case at hand.

I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

The DWC has made and proposed several changes against the stakeholders' wishes.

Instead of lowering the reimbursement rate for QMEs, the rate should actually increase. Lowering the rate will for sure cause the injured worker to suffer as it will dissuade qualified doctors from practicing medical-legal medicine.

David Scharf MD July 6, 2020

I am writing this in response to the anticipated medical legal fee schedule changes.

There are several reasonable changes postulated, and several which will destroy the QME/AME process.

Our CISMS leadership has outlined a consensus fee schedule that was agreed upon by all the shareholders; the DWC changes will only damage the agreements reached by the parties. I urge the Director to follow the consensus reached by CISMS (the doctors themselves) and the insurance carriers.

Several of the more onerous changes will lead to the drop out of the most experienced and qualified physicians. One gets what they pay for: penalize the doctors and you will have even fewer QMEs and sub-quality reports.

Several suggestions to keep the system running smoothly:

1. Appointment letters and records must arrive ***before*** the date of the exam. Far too frequently, I examine the applicant and then dictate the med legal report. Several days later the records come from one of the attorney's offices. This is a waste of time. The appointment date was set 60 days earlier, it is laziness to wait until after the exam to send the pertinent records. I complete my reports on time, this should also be obligatory on the attorneys and insurance companies. This leads me to the second point:
2. Under no circumstance will I issue a "remedial" supplemental report for free. If the information is not available to me at the time of the exam, I cannot discuss all aspects of the case in my original report. Supplemental reports are exactly that…supplemental, based upon new or additional information provided. I have issued hundreds of reports as an AME/QME. I understand the requirements of med-legal reporting. Often, I receive a letter from one of the parties that is back-dated several weeks! Perhaps their secretarial staff never sent it out with the records on time. If the DWC allows insurance carriers to then enter a code for a 'remedial free supplemental report' (with no recourse for the physician), the entire Workers Compensation will seize up. I do not believe that an experienced AME or QME will continue to work in a system that contests their ability to be legitimately reimbursed for work done. Bottom line, this remedial free supplemental code is a no-starter. Get rid of it.

3. It is understood that certain specialists see exceedingly complex cases. As a frequent 'go-to' Neurologist for Los Angeles, Ventura, Santa Barbara and SLO counties my case load is particularly challenging with medical problems included from multiple fields/chapters in the AMA Guides. Perhaps one third of the cases that I evaluate neurologically turn out to be some form of a somatization disorder (i.e. a psychiatric manifestation of a neurologic disease or event). Other cases involve significant mental status changes or complications of other medical disorders. If the DWC is no longer considering the complexity factors, it should increase the rate for specific specialists such as psychiatry and neurology. A multiplier of two times the base rate seems most reasonable to assure that the neurologist addresses all the complexities of a catastrophic case. Otherwise one will start to see much more limited reporting i.e. limited and bland reporting which will take a very narrow approach in complex cases. This will ultimately require the parties to obtain several additional QME's instead.

In conclusion, our CISMS leadership has outlined a consensus fee schedule that was agreed upon by all the shareholders. We have not received a pay raise in 14 plus years. Quality doctors make the AME/QME system work smoothly. Injured workers need timely resolution of their cases. The system needs honest and qualified evaluators. Please listen to CISMS and their recommendations. Otherwise, doctors like me will certainly continue to migrate out of the Workers Comp system.

Franklin Carvajal Ph.D., QME July 6, 2020

I represent a coalition of psychology and psychiatry QMEs who all find the proposed fee schedule to be completely inadequate. Most have indicated that it would not be cost effective for them to continue as QMEs if this were to become the fee schedule, and they would have no option but to delist as QMEs. This would leave the QME system further decimated and ultimately harm the injured workers, particularly as psych claims are almost always initially denied, and a psych QME evaluation is imperative for the injured worker to receive treatment for industrial psych injuries. It seems the only parties who prosper from this proposed fee schedule are the insurance companies. As a member of CSIMS, it is my understanding that a number of the elements in the proposed fee schedule are substantially different from what was agreed upon in the stakeholder meeting by representatives of both insurance companies and doctors. It appears that following the meeting, despite the agreements that had been reached, the DWC made changes at their sole discretion in favor of the payers. This is disappointing at the very least and the further attrition of the QME community that this will cause will rest solely on the DWC.

It is my understanding that the psych modifier was given a mere 15 minutes of time at the end of the meeting. It seems this is the reason it was so poorly reasoned as to reach a modifier of only 1.5. This is completely inadequate for the amount of time that the interview and writing of the report takes. Psych interviews are more complicated and as indicated in the Physicians Guide and the Regs, a proper psych interview is expected to take an average of three hours. The time to write these reports is extensive due to the significant amount of information required to be obtained during the interview including a detailed social history, educational history, familial history including personal details about each family member, psychological history both personal and of the family, and work history including details and factors related to previous jobs not required to be gathered by any other QME specialties. A psych report also often requires a detailed and comprehensive description of continuous trauma including numerous specific events that occurred during the time frame that must be considered and discussed with relevance to causation. The report also frequently requires an in-depth discussion of personnel actions and an application of a Rolda analysis. The reports often require a detailed discussion of past psychological conditions or trauma, and other non-industrial factors with cogent reasoning as to how these do or do not meet the 50% or greater threshold of predominance. This is much more complicated than reports in other specialties that have a causation threshold of 1% and the comprehensive reporting that is required to meet the standard of medical legal evidence takes much longer to write than reporting for any other specialty. A modifier of 1.5 is not sufficient to compensate the psych QME adequately to complete the interview and detailed reporting required.

The modifier for psych should be 3.0, or 2.5 with additional modifiers of .5 for a Rolda analysis, ad .5 for a history of past psych including past psych claims.

The DWC is proposing to pay $3 per page for record review for pages 201-1800 and then $2 a page for any page beyond that. This is completely nonsensical, and appears to imply that somehow at page 1801 the doctor becomes faster or the review becomes easier. It is my understanding that the general consensus is that review of records should be completed at 100 pages per hour. Based on this, with the DWC “giving us a raise” by increasing the recognized billable hourly rate to $325 rather than $250, we would still be underpaid for record review by $25 an hour, and then would actually be paid LESS per hour than we are now for pages 1801+ as $2 a page equates to $200 an hour. This is unacceptable. If the concern is payers sending irrelevant or blank pages for review and this rate decrease at page 1801 is somehow supposed to even that out, then the onus of this should be on the payers.

If the DWC intends to be consistent with the new RV that is being **proposed then the rate for record review should be $3.25 per page.**

The DWC is suggesting that ANY records received before the report is submitted MUST be included in the report. What about cases where the doctor is performing a final

review of the report on the 28th day and preparing to mail it the following day and receives a record dump of an additional 2,000 pages? How would it even be possible for the doctor to review these pages and incorporate them into the report prior to the 30th day, after which time the report would be considered late and possibly non-compensable? If it is impossible for the doctor to do this, would this mean that the doctor then has to review all 2,000 pages and provide a free supplemental report of these records because they were received before the report was submitted? There must be clear and reasonable limits on when records can be received in order to require them to be included in the report. What would make sense is for it to be required that the doctor receive the records BEFORE the evaluation, at least 15 days, in order for the doctor to be able to review the records and address any issues of concern or import with the injured worker during the evaluation. This would make the most sense for a quality exam addressing all issues and would allow for the most comprehensive report. This would be in the best interest of the injured worker and the workers' compensation system. It is not unreasonable for the payers to be expected to get the records to the doctor within this time frame.

If the DWC and payers are unwilling to commit to providing records in a timely way to provide the doctor with everything needed for the most comprehensive and accurate interview and exam, then at the very least the cut off should be the day of the evaluation. **Any records received after the date of the evaluation should be considered a supplemental report.**

Lastly, much of the reason that there is a need for a fee schedule change is the lack of an annual COLA in the current fee schedule, leading to QMEs not receiving a pay increase for years. It is unconscionable that one would not be added to any new fee schedule moving forward. Any fee schedule that is proposed and finalized must include an annual COLA so that we don't find ourselves in the same place a few years down the line.

Although I am disappointed in the proposed fee schedule, I remain hopeful that the DWC is truly interested in reaching a fee schedule that is equitable to all parties including QMEs, psych QMES, and insurance companies. I implore you to consider the points in this letter and as presented by so many other QMES, and realize the importance of going back to the drawing board on the issues discussed or risk further attrition of QME evaluators at the expense of the injured worker.

Blake Thompson, MD July 6, 2020

I am concerned regarding the proposed med-legal fee schedule. I am in agreement with the recommendations of CSIMS, and have included the attachment reflecting their position.

34. a page of records must be defined as double spaced, single sided, 12 point or greater font, 81/2’ by 11’ with no condensed deposition transcripts
35. The party that submits medical records must list the records provided and attest to the number of pages under penalty of perjury. Page counts must include cover letters and any and all documents provided. Records should be submitted electronically and every page in the file counted. Records received less than 15 days prior to the date of the evaluation may be submitted as a supplemental report.
36. The fee for reviewing a page of medical records should be $3 regardless of how many pages are submitted and regardless of the type of report requested
37. A re-evaluation is an exam requested within11 months of a prior exam and where the applicant is available for evaluation within 60 days after the request. If these conditions are not met, then it is a new evaluation
38. The AME modifier should apply to all fees and all services. This includes medical record review, supplemental reports, depositions and examinations.
39. The psychology/psychiatry modifier should be at least 3x
40. Internal medicine, neurology, and pain medicine modifiers should be at least 2.0x
41. The 1.5 modifier for toxicology and oncology should apply to all reports for which toxicology or oncology is the primary focus.
42. Any physician requested to perform research should be able to bill by the hour, the number of hours by agreement prior to preparing the report
43. The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable. The DWC should retitle this "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this prior to performing the service. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b) or failed to answer a specific non-hypothetical question not requiring research. Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

44. An automatic annual COLA increase should be included in the fee schedule. We recommend using DWC's own metric of Statewide Average Weekly Wage as the basis for the automatic, self-executing COLA increase.

Bobbie McDonald, PsyD, QME July 6, 2020
Licensed Psychologist

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specialties that have a low causation threshold and the comprehensive reporting that is required to meet the standard of medical legal evidence takes much longer to write for psych QMEs than reporting for any other specialty. A modifier of 1.5 is not sufficient to compensate the psych QME adequately to complete the interview and detailed reporting required.

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If the DWC intends to be consistent with the new RV that is being **proposed then the rate for record review should be $3.25 per page.**

The DWC is suggesting that ANY records received before the report is submitted MUST be included in the report. What about cases where the doctor is performing a final review of the report on the 28th day and preparing to mail it the following day and receives a record dump of an additional 2,000 pages? How would it even be possible for the doctor to review these pages and incorporate them into the report prior to the 30th day, after which time the report would be considered late and possibly non-compensable? If it is impossible for the doctor to do this, would this mean that the doctor then has to review all 2,000 pages and provide a free supplemental report of these records because they were received before the report was submitted? There must be clear and reasonable limits on when records can be received in order to require them to be included in the report. What would make sense is for it to be required that the doctor receive the records BEFORE the evaluation, at least 15 days, in order for the doctor to be able to review the records and address any issues of concern or import with the injured worker during the evaluation. This would make the most sense for a quality exam addressing all issues and would allow for the most comprehensive report. This would be in the best interest of the injured worker and the workers'

compensation system. It is not unreasonable for the payers to be expected to get the records to the doctor within this time frame.

If the DWC and payers are unwilling to commit to providing records in a timely way to provide the doctor with everything needed for the most comprehensive and accurate interview and exam, then **at the very least the cut off should be the day of the evaluation. Any records received after the date of the evaluation should be considered a supplemental report.**

Lastly, much of the reason that there is a need for a fee schedule change is the lack of an annual COLA in the current fee schedule, leading to QMEs not receiving a pay increase for years. It is unconscionable that one would not be added to any new fee schedule moving forward. Any fee schedule that is proposed and finalized must include an annual COLA so that we don't find ourselves in the same place that we are now, a few years down the line.

Although I am disappointed in the proposed fee schedule, I remain hopeful that the DWC is truly interested in reaching a fee schedule that is equitable to all parties including QMEs, psych QMES, and insurance companies. I implore you to consider the points in this letter and as have been presented by so many other QMES, and realize the importance of going back to the drawing board on the issues discussed or risk further attrition of QME evaluators at the expense of the injured worker.

Reina Archuleta, CPC, CPCO, CPC-1 July 6, 2020
Eval-Docs, Inc., Compliance Officer

I work with QME and AME physicians and I offer these comments from a coding perspective:

1. Missed appointments. The language on the missed appointments needs to be more specific to include:
    a. Late cancellations. (already addressed in the proposed fee schedule)
    b. Applicant's failure to show up for the appointment or showing up more than 30 minutes late.
    c. Interpreter failure to show up for the appointment or showing up more than 30 minutes late.
    d. Evaluation is terminated due to applicant being under the influence of sedatives, alcohol or illicit drugs.

2. Page count. This could become a nonsensical issue of "he said, she said". The page count should be included in the advocacy letter or the correspondence from the party submitting the records to the physician for review and reporting. Absent that information, the physician reporting under penalty of perjury should be deemed accurate for billing purposes.

    a. As a side note, it makes no sense for the value to go down after 2000 pages. What is the logic behind that? Is the physician going to review those pages at a faster speed? Are the pages after 2000 going to be less important? or perhaps double spaced? Time is time. If anything, the larger the volume of records, the more intense the review because the physician oftentimes must go back and forth between the records when there seems to be any discrepancies.

3. Re-Evaluation. This is changing from 9 months to 24 months.There should be an exception to this. If the physician is being asked to evaluate the applicant for a new injury such as a C.T. claim or injury to new body parts, then this should be considered a new evaluation. According to the DWC Physician Fee Schedule Regulations, a new evaluation is defined as follows: CCR § 9789.12.11 Evaluation and Management: Coding – New Patient; Documentation*"(1 A "new patient" is one who is new to the physician or medical group or an established patient with* ***a new industrial injury or illness****. Only one new patient visit is reimbursable to a single physician or medical group per specialty for evaluation of the same patient relating to the same incident, injury or illness.(2) An "established patient" is a patient who has been seen previously for the same industrial injury or illness by the physician or medical group."*
    The goal, as I understand it, is to set a fee schedule that:

a. adequately compensates the physicians and,

b. reduces or, better yet, eliminates fee schedule coding/billing disputes.

Sandra Klein, Ph.D. July 6, 2020

I have performed psychological and neuropsychological QME/AME evaluations for many years. The proposed changes are not acceptable and should be modified. The 1.5 modifier for psychological/psychiatric evaluations is too low for the increased time and complexity of these cases. It should be increased at least to 2.0 and apply to record review fees as well. The AME modifier should also apply to record review fees.

The follow up fee is too low considering that this is often when P&S ratings and other issues are addressed once the examinee has completed treatment. The fee should be closer to the basic fee and the time frame be shortened back to 9 months as it is currently. Beyond that, one is often essentially seeing a new or very different case requiring extensive interview and analysis.

Scott Small, D.O. July 6, 2020
IPM Medical Group Inc.

Here are my comment on the fee schedule.

45. a page of records must be defined as double spaced, single sided, 12 point or greater font, 81/2' by 11' with no condensed deposition transcripts
46. The party that submits medical records must list the records provided and attest to the number of pages under penalty of perjury. Page counts must include cover letters and any and all documents provided. Records should be submitted electronically and every page in the file counted. Records received less than 15 days prior to the date of the evaluation may be submitted as a supplemental report.
47. The fee for reviewing a page of medical records should be $3 regardless of how many pages are submitted and regardless of the type of report requested
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49. The AME modifier should apply to all fees and all services. This includes medical record review, supplemental reports, depositions and examinations.
50. The psychology/psychiatry modifier should be at least 3x
51. Internal medicine, neurology, and pain medicine modifiers should be at least 2.0x
52. The 1.5 modifier for toxicology and oncology should apply to all reports for which toxicology or oncology is the primary focus.
53. Any physician requested to perform research should be able to bill by the hour, the number of hours by agreement prior to preparing the report
54. The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable. The DWC should retitle this "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this prior to performing the service. Third, the scope of what would qualify for such an evaluation should be narrowed to only include

circumstances in which the QME allegedly violated 10682(b) or failed to answer a specific non-hypothetical question not requiring research. Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

55. An automatic annual COLA increase should be included in the fee schedule. We recommend using DWC's own metric of Statewide Average Weekly Wage as the basis for the automatic, self-executing COLA increase.

Andrew Levine, Ph.D., ABPP, QME
Board Certified Clinical Neuropsychologist
Associate Clinical Professor
Department of Neurology
UCLA – David Geffen School of Medicine

July 6, 2020

I am a Psychologist QME and am disheartened to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process. It is especially troubling that the DWC violated the stakeholder agreements in order to favor the insurance carriers. This betrayal of their colleagues that provide the foundation of the WC process is extremely upsetting, shortsighted, and damaging for both the QME providers and DWC in the long term.

Specifically, DWC made the following changes against the stakeholders' wishes:

	DWC Stakeholder Meetings	**California DWC Proposal**
Reimbursement per page	$3 (starting on page 201)	$3.00 (pages 201 – 2000) **$2.00 (pages 2001+)**
Definition of page	8 ½ x 11”	8 ½ x 11” OR **8 ½ x 14”**

	DWC Stakeholder Meetings	**California DWC Proposal**
Definition of re-evaluation	9 or 12 months	**24 months**
AME Modifier	1.25x and applies to **all services**	1.35x but applies **only to flat fee and not to depositions**
Medical records required to be sent 15 days prior to evaluation	Yes	**No**
Cover letter required to specify number of pages sent to doctor?	Yes	**No**
Automatic Annual COLA Increase?	DWC refused to hear this issue in the stakeholder meetings	**No**

DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation

- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.

- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.

- The mental health modifier should be increased to 3.0x

- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)

- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report

- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of

the evaluation. It should not be restricted only to QMEs board certified in these specialties.

- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Howard Rome, Ph.D. July 6, 2020
IPM Medical Group Inc.

I agree with CSIMS position on necessary revisions to DWC fee schedule proposal

56. a page of records must be defined as double spaced, single sided, 12 point or greater font, 81/2' by 11' with no condensed deposition transcripts
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Neesha Dave, DO July 6, 2020
IPM Medical Group, Inc.

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William Tappin, Esq. July 7, 2020
Tappin and Associates

The ML-204 procedure description relating to medical-legal provider testimony should be clarified. As stated in the proposed regulation, it states the physician "shall be entitled to fees for all itemized reasonable and necessary time spent related to the testimony, including reasonable preparation and travel time. Is there any guidance available for the amount considered "reasonable and necessary time spent related to the testimony including reasonable preparation?"

ML-204 goes on to state "the physician shall be paid a minimum of 2 hours for a deposition." This is poorly worded. Is the 2 hours for the deposition or for preparation and deposition?

The third ML-204 relates to cancellation fewer than 8 days before the scheduled deposition date and indicates the physician shall be paid a minimum of 1 hour for the scheduled deposition.

Does this infer that there was no "reasonable preparation time done prior to 8 days before the deposition? Additionally, it is generally true that parties scheduling the

deposition of medical- legal providers schedule 1 hour. However, on many cases, they schedule more than 1 hour. Should the language "or the amount of time requested by a party to be set aside for the deposition" be added to the last sentence?

You've indicated travel time in ML-204. After the initial medical-legal evaluation, the parties can agree to have any subsequent evaluations done at a location other than that location on the random panel document. Does the deposition have to be at the location where the evaluation took place, or can it be done at some other location? Can the parties agree at the time of the scheduling of the evaluation that any deposition will be done in the doctor's primary office location?

I think it is necessary to clear up these questions to avoid disputes. Additionally, I advise most doctors that they should read and sign the depositions as opposing to waiving signatures.

There are often mistakes in the court reporter's transcript or the doctor may have misheard or misunderstood the question. When doctors ask to review and sign the deposition, they should be given an additional ½ hour to do so.

Jeff Jones, M.D. July 6, 2020
IPM Medical Group Inc.

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82. The AME modifier should apply to all fees and all services. This includes medical record review, supplemental reports, depositions and examinations.
83. The psychology/psychiatry modifier should be at least 3x

84. Internal medicine, neurology, and pain medicine modifiers should be at least 2.0x
85. The 1.5 modifier for toxicology and oncology should apply to all reports for which toxicology or oncology is the primary focus.
86. Any physician requested to perform research should be able to bill by the hour, the number of hours by agreement prior to preparing the report
87. The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable. The DWC should retitle this "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this prior to performing the service. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b) or failed to answer a specific non-hypothetical question not requiring research. Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.
88. An automatic annual COLA increase should be included in the fee schedule. We recommend using DWC's own metric of Statewide Average Weekly Wage as the basis for the automatic, self-executing COLA increase.

Carl Fieser, M.D. July 6, 2020

I agree with CSIMS position on necessary revisions to DWC fee schedule proposal

89. a page of records must be defined as double spaced, single sided, 12 point or greater font, 81/2' by 11' with no condensed deposition transcripts
90. The party that submits medical records must list the records provided and attest to the number of pages under penalty of perjury. Page counts must include cover letters and any and all documents provided. Records should be submitted electronically and every page in the file counted. Records received less than 15 days prior to the date of the evaluation may be submitted as a supplemental report.
91. The fee for reviewing a page of medical records should be $3 regardless of how many pages are submitted and regardless of the type of report requested

92. A re-evaluation is an exam requested within11 months of a prior exam and where the applicant is available for evaluation within 60 days after the request. If these conditions are not met, then it is a new evaluation
93. The AME modifier should apply to all fees and all services. This includes medical record review, supplemental reports, depositions and examinations.
94. The psychology/psychiatry modifier should be at least 3x
95. Internal medicine, neurology, and pain medicine modifiers should be at least 2.0x
96. The 1.5 modifier for toxicology and oncology should apply to all reports for which toxicology or oncology is the primary focus.
97. Any physician requested to perform research should be able to bill by the hour, the number of hours by agreement prior to preparing the report
98. The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable. The DWC should retitle this "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this prior to performing the service. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b) or failed to answer a specific non-hypothetical question not requiring research. Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.
99. An automatic annual COLA increase should be included in the fee schedule. We recommend using DWC's own metric of Statewide Average Weekly Wage as the basis for the automatic, self-executing COLA increase.

Kenneth Kim, M.D. July 6, 2020

I agree with CSIMS position on necessary revisions to DWC fee schedule proposal

100. a page of records must be defined as double spaced, single sided, 12 point or greater font, 81/2' by 11' with no condensed deposition transcripts
101. The party that submits medical records must list the records provided and attest to the number of pages under penalty of perjury. Page counts must include

cover letters and any and all documents provided. Records should be submitted electronically and every page in the file counted. Records received less than 15 days prior to the date of the evaluation may be submitted as a supplemental report.

102. The fee for reviewing a page of medical records should be $3 regardless of how many pages are submitted and regardless of the type of report requested
103. A re-evaluation is an exam requested within11 months of a prior exam and where the applicant is available for evaluation within 60 days after the request. If these conditions are not met, then it is a new evaluation
104. The AME modifier should apply to all fees and all services. This includes medical record review, supplemental reports, depositions and examinations.
105. The psychology/psychiatry modifier should be at least 3x
106. Internal medicine, neurology, and pain medicine modifiers should be at least 2.0x
107. The 1.5 modifier for toxicology and oncology should apply to all reports for which toxicology or oncology is the primary focus.
108. Any physician requested to perform research should be able to bill by the hour, the number of hours by agreement prior to preparing the report
109. The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable. The DWC should retitle this "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this prior to performing the service. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b) or failed to answer a specific non-hypothetical question not requiring research. Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.
110. An automatic annual COLA increase should be included in the fee schedule. We recommend using DWC’s own metric of Statewide Average Weekly Wage as the basis for the automatic, self-executing COLA increase.

I am a physician and an Primary Treating Physician of workers' compensation patients and have learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

Unfortunately (but not surprisingly given DWC's demonstrated track record of bias towards insurance company interests and against injured workers and medical providers), DWC violated the stakeholder agreements in order to favor the insurance carriers.

Specifically, DWC made the following changes against the stakeholders' wishes:

	DWC Stakeholder Meetings	**California DWC Proposal**
Reimbursement per page	$3 (starting on page 201)	$3.00 (pages 201 – 2000) **$2.00 (pages 2001+)**
Definition of page	8 ½ x 11"	8 ½ x 11" OR **8 ½ x 14"**
Definition of re-evaluation	9 or 12 months	**24 months**
AME Modifier	1.25x and applies to **all services**	1.35x but applies **only to flat fee and not to depositions**
Medical records required to be sent 15 days prior to evaluation	Yes	**No**
Cover letter required to specify number of pages sent to doctor?	Yes	**No**

	DWC Stakeholder Meetings	California DWC Proposal
Automatic Annual COLA Increase?	DWC refused to hear this issue in the stakeholder meetings	**No**

DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- The mental health modifier should be increased to 3.0x
- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)

- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report

- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.

- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Kasra Amirdelfan, M.D. July 6, 2020

Please consider the following revisions as a part DWC reform for medical legal evaluations. Thank you.

1) a page of records must be defined as double spaced, single sided,12point or greater font, 81/2’ by 11’ with no condensed deposition transcripts
2) The party that submits medical records must list the records provided and attest to the number of pages under penalty of perjury. Page counts must include cover letters and any and all documents provided. Records should be submitted electronically and every page in the file counted. Records received less than 15

days prior to the date of the evaluation may be submitted as a supplemental report.

3) The fee for reviewing a page of medical records should be $3 regardless of how many pages are submitted and regardless of the type of report requested
4) A re-evaluation is an exam requested within11 months of a prior exam and where the applicant is available for evaluation within 60 days after the request. If these conditions are not met, then it is a new evaluation
5) The AME modifier should apply to all fees and all services. This includes medical record review, supplemental reports, depositions and examinations.
6) The psychology/psychiatry modifier should be at least 3x
7) Internal medicine, neurology, and pain medicine modifiers should be at least 2.0x
8) The 1.5 modifier for toxicology and oncology should apply to all reports for which toxicology or oncology is the primary focus.
9) Any physician requested to perform research should be able to bill by the hour, the number of hours by agreement prior to preparing the report
10) The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable. The DWC should retitle this "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this *prior to performing the service*. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b) or failed to answer a specific non-hypothetical question not requiring research. Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.
11) An automatic annual COLA increase should be included in the fee schedule. We recommend using DWC's own metric of Statewide Average Weekly Wage as the basis for the automatic, self-executing COLA increase.

Michael D. Angioli, Ph.D., ABPP, QME July 6, 2020

A modifier of 1.5 is not sufficient to compensate a QME in psychology or psychiatry. The modifier should be 3.0. The psychological interview requires a gathering of extensive information far greater than any other specialty. These interviews often take longer than three hours. The information must then be incorporated in a comprehensive report and

a lengthy discussion of how each of these factors does or does not play a role in causation and apportionment. Psych is the only specialty that has a causation threshold of predominance. This requires a much more extensive and detailed discussion for both causation. Psychological reports also frequently require a lengthy discussion of personnel actions and a Rolda analysis, which takes further time.

It makes no logical sense that records 1801 and beyond will take less time to review than the first 1800 pages. There should be a flat fee for all pages of $3.25 for all pages reviewed, which is consistent with the proposed new hourly rate of $325 an hour. There also needs to be clear stipulation that double sided pages count as two pages, condensed depositions count as 4 pages, and a standard page size is 8.5x11.

There must be a more adequate deadline regarding receipt of records. If a doctor has plans to complete the report on the 27th day and mail., but on the 26th day receives 1000 additional pages of records, it would be impossible to review and include these records in the report. The proposed time frame is flawed because of this. A reasonable cut off date would be the date of the evaluation.

Even the current fee schedule recognizes a nine month cut off for re-evaluations. This being extended to 24 months is not acceptable. There is too much interim information to be assessed to be paid at the lower re-eval rate beyond 12 months.

The DWC must add an automatic annual fee increase so that QMEs are not without a raise for several years as has occurred since the last fee schedule change. A fee schedule that does not include this will be incomplete. There must be a COLA included with the fee schedule so that the rate that QMEs are paid does not rapidly become inadequate, bringing us back to the problems that is occurring now.

If the proposed fee changes are implemented as suggested by the DWC, many QME's will cease being providers. These reports are very labor intensive and time consuming. Any decrease in rates will force doctors to better utilize their professional time elsewhere.

Matthew Johnson, D.O. July 6, 2020
IPM Medical Group, Inc.

I agree with the current CSIMS position on revisions to the fee schedule. The current proposal should be revised to include:

1) A page of records must be defined as double spaced, single sided, 12point or greater font, 81/2' by 11' with no condensed deposition transcripts

2) The party that submits medical records must list the records provided and attest to the number of pages under penalty of perjury. Page counts must include cover letters and any and all documents provided. Records should be submitted electronically and every page in the file counted. Records received less than 15 days prior to the date of the evaluation may be submitted as a supplemental report.
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9) Any physician requested to perform research should be able to bill by the hour, the number of hours by agreement prior to preparing the report
10) The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable. The DWC should retitle this "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this *prior to performing the service*. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b) or failed to answer a specific non-hypothetical question not requiring research. Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.
11) An automatic annual COLA increase should be included in the fee schedule. We recommend using DWC's own metric of Statewide Average Weekly Wage as the basis for the automatic, self-executing COLA increase.

Neil Steinberg, Ph.D July 6, 2020

After 13 years of no COLA increases for QME psychologists and psychiatrists, the DWC is now proposing fee reductions. This is an insult and would result in many QMEs discontinuing the provision of these services. If the goal is to reduce services and resultantly reduce costs to insurance companies, this is a wise move by the DWC. If the goal is to provide needed services to injured workers, the fee schedules should reflect COLA increases both retrospectively and moving forward.

Gary M. Stewart, M.D., AME July 6, 2020
QME (dating from the very first QME certification examination)

My name is Gary M. Stewart, M.D. I have been performing workers' compensation evaluations in the field of internal medicine in California since 1981.

I routinely perform AMEs in highly complex cases involving massive record review and multiple named body systems.

All parties, for decades, have communicated to me on innumerable occasions that they appreciate the in-depth analysis, commentary and case formulations I provide in my medical-legal reporting. My bills are paid promptly and in full, almost without exception.

The new schedule will make it impossible for me to continue to provide the quality reporting that the parties expect from me and rely upon.

Counting pages is tedious and time-consuming - who is going to do that? I recently did a report that included Kaiser records with multiple thousands of pages.

There is no way that I can justify spending the time necessary to review a deposition if it is being paid at $2 or $3 per page.

Reviewing handwritten progress notes is also extremely time-consuming and cannot be accomplished at the payment rate named.

What is going to happen is that the bills will be submitted based upon the number of pages, and there will be no commentary or analysis at all - the parties will have less certainty, litigation will be even more prolonged than it is now. Why would anyone, and especially a QME working for a QME medical group, spend time on a longer, more thorough report if the bill is going to be the same, regardless, based solely upon the number of pages of records reviewed? That is obvious.

The concept of requiring a physician to respond to questions in a new and distinct medical report and then be told that there will be no payment because there was "no new question" is a non-starter. The supplemental report will be one sentence.

It is not unreasonable to provide a modest increase in the payment schedule for basic reports, or even reports that involve a modest set of records for review (e.g., no more than 250-pages), but there should be maintained a mechanism that addresses the most complex cases and allows for a billing schedule that will support the creation of a report that the parties need, and want. The reliance on page-counts only will not accomplish that. It will prevent it.

The multiplier for mental health but not internal medicine makes zero sense, in my view. I routinely review psychiatric reporting that is far less complex than my own - in fact, it is exceptional that I encounter reports, including mental health reporting, that even approximates the complexity of what I routinely submit.

Internal medicine involves just as much or more of an interplay of multiple systems over long periods of time as is found in any other specialty, and incorporates a detailed understanding of the impact of the musculoskeletal and other system issues. that is not the case in reverse. Orthopedists are required to give very little attention to internal medicine issues. Psychiatrists have no special knowledge about physical illness and are very poorly equipped to understand internal medicine issues. On the other hand, every internist's practice has a large component of mental health.

There is a special need in internal medicine to review records very closely to glean the data that provides a reasonable basis for medical-legal analysis. Such data may be spread thinly over a massive volume, or may only be located at one to two spots in a massive file spanning a decade or two.

Preserve a mechanism to allow internal medicine to be paid commensurate with the complexity of the evaluations and reporting involved. Otherwise, the reporting will become anemic, and everyone loses. There will also be no substantial cost-savings, since the delays and additional litigation will chew up any initial reductions in reporting costs. Besides, the percentage of medical-legal reporting that is internal medicine is relatively small.

Jacob Rosenberg MD, QME, President CSIMS July 6, 2020

As President of CSIMS I am writing to inform the DWC of our consensus opinion on the current DWC fee schedule proposal.

The CSIMS board is deeply disappointed in the DWC abandoning the stakeholder negotiated fee schedule. Every change made by the DWC favors payers at the expense of providers. Given the DWC's inability to propose an adequate fee schedule over the last two years their hubris in altering the stakeholder fee schedule is shocking. In the

context of the auditors report it emphasizes how biased the DWC continues to be in favoring payers, despite the public rebuke of their prior tactics by the auditor and the audit committee.

CSIMS explanation of necessary changes

1. a page of records must be defined as double spaced, single sided,12point or greater font, 81/2’ by 11’ without condensed deposition transcripts
2. The party that submits medical records must list the records provided and attest to the number of pages under penalty of perjury. Page counts must include cover letters and any and all documents provided. Records should be submitted electronically and every page in the file counted. Records received less than 15 days prior to the date of the evaluation may be reviewed and submitted as a supplemental report.
3. The fee for reviewing a page of medical records should be $3 regardless of how many pages are submitted and regardless of the type of report requested.
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9. Any physician requested to perform research should be able to bill by the hour, the number of hours by agreement prior to preparing the report.
10. The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable. The DWC should retitle this "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this *prior to performing the service*. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b) or failed to answer a specific non-hypothetical question not requiring research. Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and

be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

11. An automatic annual COLA increase should be included in the fee schedule. We recommend using DWC's own metric of Statewide Average Weekly Wage as the basis for the automatic, self-executing COLA increase.

RATIONALE FOR THE ABOVE CHANGES:

The auditor stated a 30%fee increase was appropriate

1. Defining a page and per page charges:
   a. A page of records needs to be defined; the stakeholder meeting agreed that 100 pages per hour with standard font, spacing, single-sided, and size (8 ½ x 11 NOT 8 ½ x 14) could be reviewed. Changing the page criteria changes the appropriate fee per page
   b. The rate should $3.25/page but providers made a concession in return for a $3/page rate regardless of the number of pages submitted. Pages were determined to be a stand in for complexity. Payers and the DWC refused to consider other complexity factors for reimbursement such as research, extra face-to-face time, complex apportionment, multiple body parts, unorganized medical records, late medical records, etc. Since pages are used as a proxy for complexity it makes no sense to decrease the per page fee as pages increase. Further we currently bill $250/hour or $2.50/page so $2/page is a 20% decrease in the hourly rate from our current rates which have been in effect since 2006.
2. The AME modifier, under the existing MLFS applies to all fees including record review. Under the DWC's proposal, the AME modifier would only apply to the flat fee. This means that AMEs would receive $700 more for an initial evaluation than a PQME. This is a decrease for AME evaluators relative to the premium they are currently reimbursed under today's fee schedule. Payers do not have to use an AME. In the stakeholder meetings the parties agreed to a 25% modifier for the entire fee including record review.
3. In the stakeholder meetings there was consensus that after 12 months, providers were essentially performing a new evaluation. But this involved a concession by providers. Providers felt strongly that a re-evaluation should only be defined as an evaluation taking place less than 9 months since the most recent evaluation. Almost all re-evaluations occur within 24 months. Currently a re-evaluation is defined as less than 9 months in the worker's compensation system and less than 12 months in commercial insurance. The proposed fee for a re-evaluation at $325 per hour allows for 4 hours. That includes 200 pages of records (or 2 hours of time). That allows only two hours to see the patient and write and edit a report, which is an inadequate amount of time to prepare a quality report. Re-evaluations requested 11 months after the prior evaluation can be performed at

close to one year following a prior evaluation. Determining eligibility for a re-evaluation fee should be based on the date of the request to prevent "gamesmanship in scheduling. Evaluations requested more than 11 months after a prior evaluation cannot be scheduled within a year. Therefore 11 months is the appropriate time frame for the request to minimize frictional costs.

4. The modifier for performing an evaluation assessing oncology or toxicology issues needs to be allowed for any physician performing such an evaluation without regard to board certification. The issue is that such evaluations are more complex but this complexity is not reimbursed under the proposed schedule. The modifier should be for performing the evaluation not the board certification.
5. The “remedial medical-legal evaluation” should be relabeled **“Unreimbursed supplemental medical-legal evaluation.** The current criteria are vague. The proposal as written will lead to increased friction and alienate QMEs. The potential for abuse by both the DWC for discipline and the payers to harass QMEs is staggering. The issue must be defined so that the QME provider receives notice that a non-reimbursed report is being requested. If that is not plainly stated then the supplemental report fees should apply. The rationale for demanding such a report should be spelled out in detail. If the provider objects then there must be a dispute resolution process. Given the DWC’s history of using extraordinary tactics, including underground regulations, to discipline QMEs, DWC cannot be trusted to make neutral decisions between QMEs and payors.
    a. The regulations must include exactly what is required in each report. It must be clear that physicians are not obligated to answer hypothetical questions. Only questions related to the specific case and involving specific facts are appropriate. Further questions in a supplemental report that require over 30 minutes of research must be reimbursable at an additional $325/hour.
6. The mental health (psych) modifier needs to be upgraded. While the proposed modifier came out of the stakeholder meetings, mental health providers were underrepresented at the stakeholder meetings. Meanwhile orthopedic evaluators were represented by CSIMS, the COA, orthopedic evaluators, as well as several chiropractors. No data was presented on the average time spent in mental health evaluators in face to face time as well as report preparation. On average, it appears mental health evaluators require substantially more time to complete an evaluation. Therefore, the mental health modifier should be 3.0.
7. More complex reports that sometimes require research for internal medicine and neurology also require more face to face and report preparation time thus warranting a modifier. These reports constitute less than 3%of all medical-legal reports.
8. It is obvious that a COLA increase is necessary. The DWC maintains that they are not legally permitted to provide a COLA increase for the medical-legal fee schedule despite the fact that every other fee schedule is regularly updated

(treatment fees, pharmacy charges, interpreter fees, facility fees, durable medical good fees). On the face of it this discrepancy seems unlikely. We ask that the DWC immediately request the OAL to rule on whether the DWC has statutory authority to provide a COLA increase. Such a ruling will provide a road map to the legislature as to the necessary reforms, either legislating a COLA or alternatively re-evaluating why the DWC has failed to act for 14 years while the QME population dwindled.

Anonymous July 5, 2020

The DWC is out to harm QMEs again because they are controlled by the payors. During the most recent stakeholder meeting, the DWC and the payors refused to hear any proposal to pay QMEs per hour. This automatically set the stage for causing the most harm for injured workers with complex complaints because the DWC took out payment based upon complexity of a report. That is, the meeting was already set up to fail. At the stakeholder meeting, a proxy for complexity, number of pages of records was used. This is obviously a false assumption because the parties determine what records a QME sees and does not see. You can also have an extraordinarily complex case with fewer records. Sometimes all the records are not subpoenaed. Also, we know that it may be that someone who has an extremely complex case does not come to the attention of medical providers or other systems. So, a QME could be spending many hours evaluating and writing a report and get paid only a fraction of what they should be getting paid if this new schedule is implemented. An insurance company would be financially motivated to keep records away from a QME or simply just subpoena records that will do the most damage to an applicant. So unrepresented applicants are at the biggest risk because if they don't understand that certain records may be pertinent to their case. Unrepresented employees may never realize the financial motivation by the insurance company to only subpoena certain records and only provide the QME with certain records that have harmed their claim.

Another built in false assumption at the stakeholder meeting is that QME should be paid based upon the supply and demand for QMEs. So QMEs that do ML102 and ML103 evaluation will get boost. This false notion harmed mental health QMEs. For mental health, the payors apparently have no trouble getting a panel, so were not willing to pay over the 1.5 multiplier, when in fact, a 3.0 multiplier would have been more appropriate. In fact, the mental health portion of the stakeholders meeting was embarrassingly short and harmful to mental health QMEs and their patients. I am sure that the broader mental health community and patients would be extremely upset if they knew about this. Mental health providers have to pay much more attention to many aspects of a person's history, so the examination is much longer than a simple physical injury claim. Moreover, a mental health provider has to spend much more time on the records than a

simple physical injury claim because they have to look at the records in greater detail. You can have evaluations that take 20 or 30 or more hours to complete. The DWC is basically saying that a mental health evaluation is 1.5 times at more complicated than a simple physical injury at the base. The DWC is also saying that the amount of time it takes to review the records for a simple physical injury and a mental health injury are the same because there is no multiplier for all the records. That is simply absurd and unacceptable.

Another false assumption at the stakeholder meeting was that QMEs review records at 100 pages an hour. For some specialties and simple cases, that may be the case. For more complicated cases and for evaluators that actually read the records, this is not the case. Patients who have QMEs reading records at 100 pages an hour should pay close attention to their reports and make sure they are accurate. Unfortunately, again, the unrepresented worker who knows nothing about the system would not have the sophistication necessary to challenge these reports.

The stakeholders also worked on destroying the QME system by taking out compensating for research which is needed in different cases to support opinions. Toxicology cases depend a lot on research. Many times internists need research to support their opinions and medicine is changing every day and the recommendations necessary, depend on current research.

The stakeholders were also able to get away with not paying an hourly rate for face to face time. This means that an evaluation taking one hour is compensated the same as that paying 6 hours. Injured workers complain a lot about primary treating physicians not listening to them. And they are right! You know why? It is because the DWC harmed reimbursement for consultations and many providers just opted out. As the DWC chased away many wonderful physicians acting as QMEs through their underground regulations, those same physician’s stopped treating patients in this system. All of this is tied together. So, doctors spend less time with patients and the insurance company spends a lot of time to arbitrarily deny claims. They do this because they figure that many people will just drop out and not try to appeal. For those that appeal, they go to a QME. Now, the DWC is proposing not listening to the patients with this proposal because there is no financial compensation to do so. Every extra hour represents a financial loss for the QME. So, for the most seriously injured patients and unrepresented patients that need someone to listen to them, it is much easier to deny their claim. I wonder what payors outside of the work comp system think about the potential shifting of patients onto their system.

The stakeholders were able to agree to take advantage of QMEs by adding hours of uncompensated time to their practices by making them count pages and put them in order by themselves. Doctors should not be spending time counting pages. This is more effectively done by the parties sending the pages so there is less opportunity for dispute

and someone who does a clerical job can do this. Doctors should be spending time talking to patients! Only in the DWC world can doctors now be bean counters and have to swear under penalty and perjury how many pages they get or the DWC will go after them.

The stakeholders were also able to get away with taking advantage of QMEs with no COLA increase meaning that after giving QMEs a pay cut with this proposal, the payors will be able to effectively give lower payments to QMEs over the years because they never have to adjust payments for increases in costs in this state. Everyone knows that this state become more expensive to live in and do business in every year. We already know the DWC took advantage of QMEs by not giving a COLA increase since 2006.

The stakeholders were able to get away with proposing compensating much less for supplemental reports which may take many hours and those hours are not necessarily compensated by the records provided. For example, in a supplemental report, a QME could be asked multiple questions requiring significant cognitive effort and be provided with no records. This may require many hours of thinking and developing a report and the most that could be charged is 650 if there are no records. Basically, this is free labor for very complicated supplemental reports with no records.

Another false assumption was that QMEs would financially benefit on some reports and financially lose on some reports; however, in the long run, they should financially benefit. Obviously, for those doing complicated reports, it is a constant financial loss. QMEs with the least complicated reports stand to gain the most under that false assumption. Who thinks up regulations where it is built in that some of the patients you will see will be a financial loss?

So, after years of chasing out or creating conditions for QMEs to leave, the DWC and payors were able to get a forced consensus from the stakeholder. This was based upon false assumptions, using supply and demand as the only negotiating tactic, forcing discussion of only one model of compensation, turning down reasonable hourly and complexity proposals from doctors, and cutting the mental health meeting to go home and get ready for dinner.

So, the DWC had the recommendations, from the stakeholder meetings, which would have already destroyed the QME system. The recommendations were so good for DWC and the payors that they were able to get away with paying QMEs less than they did evaluators from Nevada, a lower cost state. It seemed like the DWC and payors were on the cusp of victory in taking advantage of doctors and patients, especially those who are unrepresented and with complicated cases. Then during the pandemic, the DWC decided to propose a telehealth schedule based on the flat fees. It was every bit as terrible as the QME community thought but additionally was trying to force QMEs to count duplicate pages! Can you imagine? First, the DWC wanted to have QMEs doing

uncompensated time counting and sorting records. Then they wanted to have QMEs spend endless hours trying to figure out what was duplicate. Unfortunately for the DWC and payors, the QME community rejected that. However, the DWC has a lot of endurance when it comes to trying to take advantage of doctors and patients and trying to get the best deal for payors. The DWC decided that they wanted to make the terms even more favorable to the payors and came up with additional destructive recommendations for this new schedule:

The auditor suggested a 30% raise for QMEs. That would mean $3.25 per page. However, the disastrous stakeholder meeting left QME believing that the DWC would be proposing an even lower per page reimbursement of 3 dollars per page. Then the DWC, which is in the pocket of insurers, decided to do worse that the stakeholder meetings and propose 3 dollars per page for pages 201 to 200 and then 2 dollars per page thereafter. Even at 3.25 per page, this is much lower than lower cost Nevada which not only provides which provides $4.46 per page after page 50, but also an additional 97 cents to organize medical records not in chronological order. This proposal is a form of age an injury discrimination. Basically, the more injured and complicated a patient is, the more likely they are older, the less of a financial incentive it is to evaluate them as opposed to a healthier, younger person.

The DWC has defined a page age being 8 ½ X 11 or 8 ½ by 14. This is a new trick being introduced by the DWC and the payors to further undercut QMEs because no one uses legal sized paper. The DWC is allowing insurers to have records printed on the later 8 ½ by 14 to basically even go below their already lowball proposal by decreasing the number of pages reviewed. Should QMEs expect to get 8-point, single-spaced font next?

QMEs have been practicing for years noting that a re-evaluation occurs within nine months. Currently, it is 9 months. Strangely, the suggestion out of the DWC stakeholder meeting was 9 or 12 months, which is already a way to undercut QMEs because re-evaluations pay less even though they can be much more complicated than the original evaluation. In this proposal, the DWC wants to make recommendations that are even worse than those proposed by the stakeholder meeting by making a re-evaluation and evaluation that is done within 24 months of the original evaluation. Many significant changes can happen to someone within 24 months.

The AME modifier from the stakeholder meeting was to be 1.25 and apply to all services. The DWC has made the AME modifier to be 1.35 but only applied it to the flat fee and not deposition. This is almost as bad as not applying the mental health multiplier to all services.

The DWC has introduced a supplemental report scam into the system because it allows for so called remedial supplemental requests to be given to a QME. This is basically

allows parties to give endlessly long, overbroad cover letters that allow them, at any time to say that a QME did not do this or that. Then they don't have to pay for any supplemental report they request. Free reports! This is also a good way for parties to retaliate against a QME by issuing a remedial supplemental report. This introduces bias into the system because if QMEs are aware of who is requesting more remedial reports, they are likely to try to please the issuers of these reports by giving them a favorable opinion so that they are less likely to get a remedial supplemental request.

So, the QMEs that will do best in this proposed system will be the ones that do the worst and most barebones report. The DWC has taken out any incentive to do a good report or to deal with any complexities that may arise. What a QME can do to make the most money is spend as little time with the applicant as possible. It will be financially best to cut the applicant off if they try to start giving any lengthy explanation. Then, review records at warp speed of 100 pages an hour or more. You don't have to research anymore because the DWC is okay with less evidence supporting opinions. Then, send a small report out. There is no need to go into any in depth explanation because that does not help get better financial reimbursement. Then, QMEs will just need to make sure that they work just sufficient enough as to not get a remedial supplemental report. These QMEs can benefit because they can get more depositions which will pay at 455 dollars and hour and can answer any additional questions in non-remedial supplemental reports.

This board is open for public comment, but patients are not aware of what the DWC is proposing to harm them. Many of the sickest ones are going through financial disaster in addition to dealing with Covid and it is certain that the DWC has not reached out to them. What would help is for the DWC, when they propose regulations, to publish a paper of what assumptions they are using and what they are envisioning the system will look like.

It would be helpful to know who at the DWC and/or insurance companies came up with a worse proposal than the stakeholder meeting and the reasoning behind it. The DWC is obviously biased towards the insurance companies as everyone can see it. The DWC started off by going after QMEs for alleged fraud but it turns out one of their main intentions was to change the system outside of going through the legislature.

The current fee schedule is the best schedule. It was done at a time that there was a thoughtful DWC with stakeholders open to ideas and development over time. Increase the fees for ML 102 and 103 to the base rates in the current proposal and then leave the current fee schedule alone.

Trevor B. Mackin, PsyD, QME July 5, 2020

I am a QME and I have learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

Unfortunately (but not surprisingly given DWC's demonstrated track record of bias towards insurance company interests and against injured workers and medical providers), DWC violated the stakeholder agreements in order to favor the insurance carriers.

Specifically, DWC made the following changes against the stakeholders' wishes:

	DWC Stakeholder Meetings	**California DWC Proposal**
Reimbursement per page	$3 (starting on page 201)	$3.00 (pages 201 – 2000) **$2.00 (pages 2001+)**
Definition of page	8 ½ x 11”	8 ½ x 11” OR **8 ½ x 14”**
Definition of re-evaluation	9 or 12 months	**24 months**
AME Modifier	1.25x and applies to **all services**	1.35x but applies **only to flat fee and not to depositions**
Medical records required to be sent 15 days prior to evaluation	Yes	**No**
Cover letter required to specify number of pages sent to doctor?	Yes	**No**
Automatic Annual COLA Increase?	DWC refused to hear this issue in the	**No**

	DWC Stakeholder Meetings	California DWC Proposal
	stakeholder meetings	

DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- The mental health modifier should be increased to 3.0x
- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)

- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report

- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.

- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Unfortunately, if the DWC does not amend the proposed fee schedule, I fear a large exodus of QMEs from a system which has not afforded us a cost of living raise for many years. I may be one of those QMEs who is forced to either drastically reduce my QME work or abandon it altogether. Please help us to get back to the mutually agreed upon fee schedule items.

Kenneth R. Sabbag, MD July 5, 2020

I am writing to you again in response to the proposed fee schedule for medical legal evaluations. I have included the Nevada Fee Schedule here for your perusal. In is unconscionable to pay California doctors less than Nevada doctors for medical legal

evaluations. Note that Nevada accounts for complexity and pays for record reviews beyond 50 pages at a rate of $4.46 per page.

NEVADA FEE SCHEDULE:

INDEPENDENT MEDICAL EVALUATION REIMBURSEMENT

Nevada Specific Codes:

NV02001 Review of medical records (up to 50 pages), testing, evaluation and report $1,784.12

NV02002 Review of each additional 100 pages of medical records (shall be prorated for increments less than 100 pages) $446.04

NV02003 Evaluation of more than 2 body parts, for each body part in excess of (use body part descriptions located under Permanent Partial Disability Reimbursement) $334.52

NV02004 Organization of medical records in chronological order based on date of service per 50 pages $48.72

NV02000 Failure of an injured employee to appear for appointment $669.04

Nevada Specific Code NV02000 may only be billed if an injured employee is more than 30 minutes late for a scheduled appointment or cancels the appointment less than 24 hours before the scheduled appointment.

The medical records must be in a printable format and include a cover sheet indicating the number of pages provided to the physician or chiropractor.

All medical records are to be provided to the evaluator in chronological order based on date of service.

Separating chronologically-organized therapy notes is acceptable.

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All medical records are to be provided to the evaluator in chronological order based on date of service.

Separating chronologically-organized therapy notes is acceptable.

For the purpose of establishing the maximum allowable payment for the review of medical records and the evaluation of musculoskeletal body parts, the following constitute one body part:

a. The cervical spine
b. The thoracic spine
c. The lumbar spine
d. The pelvis
e. The left upper extremity, excluding the left hand
f. The right upper extremity, excluding the right hand
g. The left hand, including that portion below the junction of the middle and lower thirds of the left forearm
h. The right hand, including that portion below the junction of the middle and lower third of the right forearm
i. The left lower extremity
j. The right lower extremity
k. The head
l. The trunk

Please account for complexity of the evaluation in the fee schedule. Please increase the reimbursement for record reviews to $4.46 per page or higher for any and all pages after the first 50 pages.

Kenneth R. Sabbag, MD July 5, 2020

I am an orthopedic surgeon and a QME. I have reviewed the proposed DWC fee schedule. I participated in a videoconference regarding the proposed fee schedule. I have several areas of concern.

1. The complexity of the case is not considered. Many applicants, particularly the ones who enter the QME process, have multiple and complex injuries.

    a. When an applicant has three or more body parts, a premium should be paid to the QME.

    b. When an applicant has two or more dates of injury, a premium should be paid to the QME.

    c. It is a fallacy to believe that complexity of a case always correlates with the number of medical records. If asked, I can present multiple evaluations

of applicants with multiple body parts injured, multiple dates of injury, and less than 200 pages of medical records. This scenario is particularly present in our public safety officers.

Please increase the compensation for complex orthopedic cases defined as three or more body parts OR two or more dates of injury. The time and analysis required to address multiple body parts and multiple dates of injury is substantial. These complex cases need to compensate the QME or AME accordingly. I suggest an additional $1,000 per body part for three or more body parts and $1,000 per date of injury. Failure to do so will make it difficult for these injured people to get a thorough evaluation. There is no doubt that QMEs and AMEs will need to cut corners to not lose money on these complex evaluations.

2. The proposed schedule suggests that 200 pages of medical records need to be reviewed for free, Beyond that, record review is paid at a flat fee of $3 per page up to 2,000 pages.The per page fee schedule drops after that to $2/page. This is less than we get now.

    a. Medical record review takes time.

    b. Payors purge records to keep the number of pages down.

        i. Of course they do and an argument to the contrary is ignorant or asinine.

    c. An accurate history is often only available from the medical records.

    d. This is substantially less money per page than typical. **Nevada, for example, pays $4.46 per page** after the first 50 pages.

    Please match the Nevada fee schedule for record reviews. $4.46/page after the first 50 pages is fair and will enable a QME to spend the time necessary to provide and accurate and complete report. Asking for 200 pages to be reviewed for free is inequitable. California providers should not get paid less than Nevada providers.

PS – In addition, I support the CSIMS proposals with a few changes that are highlighted:

- All Pages over 50 should be reimbursed at $4.46/page.
- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be three business days prior to the evaluation not the date of issuance of the report.

Jeffrey M. Steinhardt, DC, QME
Past Member and Chairman, California Board of Chiropractic Examiners

July 5, 2020

I am a QME and CSIMS Member. I have learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

Unfortunately (but not surprisingly given DWC's demonstrated track record of bias towards insurance company interests and against injured workers and medical providers), DWC violated the stakeholder agreements in order to favor the insurance carriers.

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- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Dr. Jill Torres July 5, 2020

I am a psychologist and QME. I am writing to indicate that I believe the proposed new fees are very inadequate.

Using a flat rate of $325 as was recommended by the auditors if we are allowed $3022 for an initial QME with two hours of records this essentially means that we are being paid to complete all aspects of the report including face to face, formulation, writing, Editing, and Up to 2 hours of record Review (considering 100 pages per hour) in. 9.25 hours. If the records take 2 hours that leaves 7.25 hours for everything Else. This is very inadequate. Most QME face to face for psych is about 4 hours leaving only 3.25

hours for the formulation, dictation, and editing of the reports. As you are aware most psych reports are quite complex and frequently require a rolda analysis, which itself can take up to two hours. Then the issue of apportionment can also take a significant amount of time. I believe that a modifier of 2.0 would resolve this issue and account for the added time and complexity required.

Next, the idea that a re-evaluation 23 months after the initial evaluation should be paid significantly less is unreasonable. So much transpired during that time frame. A reduced fee for a re-evaluation up to 9 months is reasonable. This typically will allow the person to get any recommended treatment and hopefully provide a P&S report.

Third, the way I interpret the proposal records that are Submitted any time up to the day the report is issued (up to 30 days after eval) should be included in the initial evaluation and we cannot bill them as a supplemental report. It is unreasonable to expect a QME that receives the records more than one week after the exam to incorporate the records into the initial QME report. The records really should be provided in advance of the exam do the doctor can review them before the eval. I simply could not add a records review and commentary and possibly change my entire options within a few days of records (often very large volumes) are provided 10-30 days after the evaluation.

Fourth, the idea that if the parties believe an issue should have been addressed and was not in the initial QME report that we should have to issue a supplemental report for free is unfair. Nobody in this field works for free. If it is. Something that was egregiously left out of the report or completely ignored from the cover letter questions that might be acceptable however this should be a rare circumstance. If it is occurring frequently the physician should be disciplined by the DWC. As it stands now the attorneys would subjectively be able to deem that we should have addressed something and demand a free report and if we refuse we would face discipline. If there is a reason to request a free supplemental for an issue not addressed the request should be titled ‘Request for unpaid Supplemental Report” and there needs to be a mechanism to dispute this expediently with the DWC.

Fifth, page count needs to be better defined. In the medical industry the standard is letter size with hand written notes or 12pt font single spaced with double spacing between paragraphs and headings. As of now the proposal would allow legal Size records that are 27% more to a page and could be submitted in any font size. This could lead to abuse with single space legal size 8 or 10 point don’t records in order to keep page count down.

Sixth, the party sending the records needs to be responsible for verifying and certifying the page count and organizing records coherently and with an index either arranged by provider or chronologically and on single sided paper. Very often we get records that

are simply a mess and it can take hours to organize them before they can even be reviewed.

Please seriously consider these issues. As it stands now the proposal is extremely unfair and it will lead to so many unforeseen conflicts and disputed because many terms and issues are not well defined.

Robert C. Larsen, M.D., M.P.H.
Center for Occupational Psychiatry

July 5, 2020

I am the son of an immigrant who never went to high school. My great grandfather died in an industrial accident while working as a construction laborer in Chicago. Would you like to know what the family of that legal alien got? Deported back to Italy.

The workers' compensation, while caring for those with simple work-related injuries, should give special attention to employees with the most complex, life-threatening and life-changing insults. When amending the Medical-Legal Fee Schedule please keep in mind those Californians with claims involving multiple body parts having been damaged. Those are the cases that I and other seasoned colleagues evaluate and/or treat.

Before, during and after medical school I have been a worker. I was a busboy, a Teamster dock worker, a lab technician, a roofer, a research scientist and an instructor. These jobs all had certain risks, some greater than others. As a physician I have worked in E.R.s, jail wards, locked facilities, board and care homes, state hospitals, and prisons. There have been risks in those settings as well. I identify with health care workers, first responders, and essential workers who sacrifice for the rest of us, not knowing whether they will be shot, lose a limb or become paralyzed just for performing their job duties.

I write to you as a physician, first and foremost. It is true that I am trained as a cell biologist with a degree in public health and a fellowship in health policy. I am also a Clinical Professor of Psychiatry at UCSF School of Medicine. However, it is as a physician that I address the proposed changes to the MLFS. Soon after completing my residency training in 1982, I began consulting on cases of injured workers. The cases I see are complex clinically, legally and often morally. A clerk raped with a gun, a respiratory therapist having all four limbs amputated due to infection, a bank teller robbed multiple times at gunpoint, a cop unable to forgive himself for shooting a child, a firefighter helplessly watching a family burn to death in their vehicle – these are the type of serious injury claims that must be protected.

My review of the proposed changes to the MLFS concludes that many standard injury claims will be well-served. A standard all-inclusive fee with adjustments for records review may be well-intended yet will not encourage detailed reporting on the issues of diagnosis, causation of injury, extent of permanent disability, apportionment of causation, future treatment and fitness for duty. In the complicated cases, the parties and the trier of fact rely upon the QME/AME to develop the clinical facts that result in a just settlement.

I understand that there has been misuse of billable hours by evaluating physicians for research, interviewing, records review and report preparation. My concern when I consider the proposed MLFS is that workers with the most complex injuries will not be protected as the emphasis is on simplicity and developing the facts for standard injury claims.

There are aspects to the workers' comp system in California that are beneficial yet cost more when compared to states that get by with less. Not all states allow workers to be represented by attorneys. The use of AMEs is an element to California's system that is absent from other disability systems. Providing incentives for evaluating physicians to issue comprehensive reports in the claims complicated by multiple injuries, contested facts, personnel matters and exclusions based upon the Labor Code is the right decision for the employee and employer.

Yatin Patel, MD, QME July 4, 2020

The proposed changes are unacceptable. If enacted, this fee schedule will increase the administrative burden on QMEs, not compensate them fairly, and undoubtedly reduce the already record-low number of QMEs still left in the system.

DWC has intentionally NOT applied the psych multiplier to record review. This makes no sense. Reviewing medical records from a mental health perspective is inherently more time-consuming and complex than reviewing medical records for a non-psych specialist. I urge DWC to increase the multiplier to at least 2.0x **and** apply the psych multiplier to record review fees, not just the flat fee.

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders. Why has DWC ignored this widely supported proposal?

Further, the fact that DWC has disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement DWC proposes is far below Sue Honor's recommendation and even less than the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge DWC to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Jeffrey F. Caren MD July 4, 2020

I have been a QME since 2000, an AME since 2006 and am a current CSIMS member. Since the DWC 2006 QME Fee Schedule was implemented, I have become progressively dismayed by the DWC's failure to provide annual cost of living increases, which had been mandated by law. I can only speculate that this one reason physicians have dropped out of the Workers' Compensation process and others have not replaced them. I do appreciate the DWC's attempt to rectify not keeping current with the 30% increase in cost of living since 2006 and comply with the recommendations of the recent legislative audit.

I have learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

Unfortunately (but not surprisingly given DWC's demonstrated track record of bias towards insurance company interests and against injured workers and medical providers), DWC violated the stakeholder agreements in order to favor the insurance carriers.

Specifically, DWC made the following changes against the stakeholders' wishes:

	DWC Stakeholder Meetings	**California DWC Proposal**
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Medical records required to be sent 15 days prior to evaluation	Yes	**No**
Cover letter required to specify number of pages sent to doctor?	Yes	**No**
Automatic Annual COLA Increase?	DWC refused to hear this issue in the stakeholder meetings	**No**

DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page
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- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- The mental health modifier should be increased to 3.0x
- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)
- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report
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such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.
- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Tulsidas Gwalani MD July 4, 2020

I am a QME. I have learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

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- The mental health modifier should be increased to 3.0x

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- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

William J. Previte
The SPORT Institute Medical Group, Inc.

July 4, 2020

As a QME and CSIMS member, I am aware of the DWC/stakeholder meetings conducted in regard to the MLFS matters. I am aware that a “negotiated in good faith” outcome resulted with a mutually agreed upon schedule between payors and providers. I am both disappointed and appalled to learn that the DWC ignored those proceedings and failed to honor the negotiations.

It is apparent that (although touted as a neutral organization) the DWC demonstrates consistent bias in favor of the insurance company interests with consistent adverse perspective toward the injured workers and providers.

The DWC violates the stakeholder agreements in numerous areas:

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- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Daniel Buch, BS, DC,QME July 4, 2020

Thank you for your continued deliberations regarding the MLFS process. As a QME since 2001 and as a DWC approved provider of QME continuing education since 2008, I have received continuing and numerous questions and concerns regarding the MLFS. I have also witnessed a continued and serious decline in QME moral over the years. I

have received many comments from QMEs who continue to feel devalued and disrespected by the system. This has occurred during a time where QMEs must cope with ever-increasing complexities involved in modern evaluations, including Almaraz Guzman and apportionment.

While I believe that a flat fee schedule may be the best solution to this difficult problem, the current proposed MLFS does little or nothing to ease the devaluation of the physician's time while placing additional clerical duties upon the QME.

> 1) One of my primary misgivings about the new proposal is that the proposal seriously undervalues the Supplemental Report. Under the proposal it is probable that the QME will be obligated to provide supplemental reports for NO payment. This could occur in situations when the QME omitted, by no fault of their own, to address an issue that any party believes "should have been addressed."
>
> The QME would be obligated to perform and serve a "Remedial Supplemental Medical-Legal Evaluation". Should no such report be served by the QME, the "Administrative Director or his or her designee" will have grounds to discipline the QME.
>
> Understand that one of the most complicated duties of the serving QME is determining "what the issues are". While the labor code dictates what the mandatory headings of the report are, there are very often VERY SPECIFIC issues which may require the QME's opinion. Often, these specific issues are not conveyed by the Parties to the QME and the QME is left to "sort it out".
>
> By offering a discounted Supplemental Report fee and by requiring the QME generate a "Remedial Supplemental Medical-Legal Evaluation" offering NO compensation, the Proposal not only devalues and disrespects the physician. **Even the very nomenclature of the "Remedial Supplemental Medical-Legal Evaluation" is offensive and serves as a slap to the face of the QME.**
>
> **Understand; this is a major concern.** A party could simply state that the QME's report failed to address a certain issue, which could either be unrequested OR not required by the Labor Code, and deny compensation. Should the QME fail to serve the FREE report. the party could also then report the QME to the Medical Unit for "disciplinary action". The burden would yet again fall on the QME to prove that the issue raised was either not requested or not required by the Labor Code.
>
> This is just another way for the Carrier to both shift clerical responsibility to the QME and as a means to delay or deny reimbursement, with the QME carrying

the full burden. **All of this with NO new rules to hold Carriers accountable for such accusations and denials of payment. This represents nothing more than another slap to the face of QMEs.**

2) There is no reasonable cost of living adjustment (COLA) in the new proposal. Physicians in California have increasingly found the responsibilities and difficulties of serving as a QME unrewarding. The new proposed MLFS has been pointed out by others to offer lower reimbursement than the Nevada Fee Schedule; a state with a lower cost of business and living than California. In California there has been no COLA the MLFS in 14+ years. I know of few professions which have endured such devaluation of their services.

3) The proposed MLFS requires 200 pages of medical record review prior to a separate fee being charged for such record review. Even the Nevada Fee Schedule caps the record review at 50 pages prior to additional fees. Once again, the proposed fee schedule devalues and disrespects the QME. The QME will also be required to organize and count the pages reviewed. Again, the Nevada system requires that the Carrier organize and count the pages submitted for review. Under the new proposals, the California QME will be required to perform this clerical detail, with no reimbursement.

I believe the above represent my gravest concerns regarding the newly proposed MLFS. I hope the parties involved will attempt to respect the difficulties involved in serving as a QME in California and offer some amendments to the proposed MLFS which will better reflect that respect.

Douglas Owen, D.C. July 4, 2020

I believe that the flat fee as proposed is fair except that I feel the number of pages included in flat fee should be 100 not 200.

The reimbursement per page of $3.00 is fair after first 100 pages, but why lower the reimbursement after 2,000 pages? This makes no sense because the more pages of records there are to review then usually the more complicated is the case. The reimbursement fee should be the same no matter how many pages are reviewed after the first 100.

Regarding the ordering of the dates of medical records, I feel that the state of Nevada has this one right. Either it should be required that the medical records are placed in order by the insurance company or there should be reimbursement to the doctor if I am required to do it. This takes time and I should be paid for my time and I believe $1.00 per page is fair.

The failed appointment fee is fair enough, however it should include reimbursement for when an interpreter doesn't show up. The insurance company is responsible to provide an interpreter. I can't tell you how many times they have screwed up and not sent an interpreter and I have driven for over an hour to get to the appointment and then I get no reimbursement for my time that *they* wasted it by failing to send an interpreter.

There should be a cover letter from the insurance company specifying the number of pages of records which were sent. In that way any discrepancy between the count by the insurance carrier and the count that I make can be settled up front instead of giving them the leverage to deny payment for my bill after the work has already been performed.

Regarding the issue of COLA: For over 14 years I have been paid the same amount for my reports. This is completely unfair. Reimbursement for my time should be compensated with a rate increase for cost of living at least every 2 years.

Regarding reimbursement for medical research: Medical research is rarely necessary for doctors like myself who have been doing this for over 25 years, however when it is necessary we should be reimbursed for our time spent doing research on complicated cases. The reimbursement rate should be $250 per hour spent in research.

Supplemental reports should be paid a flat fee of $250 per hour for review of records and writing the report with a minimum charge of one hour. In this case I believe that Sue Honor's recommendations should be adapted as follows:

"The way in which an unreimbursed “remedial supplemental evaluation” is defined is unacceptable and unfair to QMEs. DWC should rename this to “unreimbursed supplemental evaluation” to clarify the intent of this “service.” Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, “Request for Unreimbursed Supplemental Evaluation” so that the QME is aware of this prior to performing the service. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs."

And finally I agree with Suzanne Honor's recommendation that a re-evaluation should be within 9 months of the last med-legal exam, not 24 months.

Thank you in advance for your fair minded consideration and efforts in this matter. I hope that you will consider these suggestions as well as all of the other recommendations from my colleagues. The success or failure of the Qualified Medical Evaluator's role in the California Worker's Compensation system is dependent on the decisions that you make in this matter.

Roger Nacouzi MD July 3, 2020

Comment on proposed medical-legal fee for internal or cardiovascular QME evaluation

The proposed flat fee for initial QME exam, follow up exam or supplemental report may work for a simple injury involving a single body part, but does not come remotely close to cover basic cost of a 200 page internal or cardiovascular comprehensive evaluation because most of the time there is a need to analyze in detail controversial physical and emotional factors involving multiple body parts, review multiple orthopedic and psychiatric evaluations, consider toxic/infectious/carcinogenic factors, search medical literature, review depositions and statements in addition to medical records that can all be packaged in a file close to 200 pages.

- The fee for each evaluation should be more than doubled from the current (20 y/o) relative value of $ 12.5 per unit of time to $ 30 per unit of time
- Keep all the current ML codes, including ML 104. The complexity of the evaluation is the major factor determining the appropriate level of service.
- No show / Late cancellation fee $ 800 to discourage misuse of QME time

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Pavel Moldavskiy, MD, QME July 3, 2020

The proposed changes are unacceptable. I am not sure what justification can be used to explain how the reimbursement paid to IMEs in Nevada is reimbursed at a higher rate.

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

The fact that you have disregarded essentially all of Sue Honor’s qualitative suggestions

is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

Scott T. Anderson, MD, PhD, FACP, FACR July 3, 2020

I recommend higher rates of reimbursement for the extensive record reviews and analytic effort required for internal medicine assessments.

Elliot Gross MD July 3, 2020

The California Division of Worker's Compensation ("DWC") just proposed a new fee schedule for Qualified Medical Evaluators which is grossly inadequate and will place injured workers at risk. Injured workers rely on QMEs in order to have their claims handled timely. The California State Auditor already found that the DWC has systematically mismanaged the QME program. DWC should not be permitted to continue to drive it into the ground by breaking an agreement reached during the stakeholder meetings. I am a QME and would like your help dealing with the DWC's misguided proposal which will hurt injured workers in your district.

- QMEs are the referees in the worker's comp system. They help settle medical disputes.
- The number of QMEs has been shrinking over the past 5 years and now is at an all-time low. This is because DWC has refused to increase rates for QMEs since 2006 even though the law requires they do it every year.
- In 2019, a report from the California State Auditor showed that DWC has not done enough to keep QMEs in the system. JLAC (Joint Legislative Audit Committee) held an oversight hearing on this in January 2020.
- In January 2020, CalMatters ran a story on the lack of QMEs and how DWC's mismanagement has harmed injured workers throughout

California:https://calmatters.org/health/2020/01/california-workers-comp-delays-injuries-audit-failings/

- DWC is proposing to update the fee schedule but they are doing it in a way to favor insurance companies and hurt QMEs and most importantly, injured workers. DWC held a stakeholder process involving medical groups and payors. The stakeholders agreed to a fee schedule. But now DWC is proposing to pay the QMEs even less than the payors agreed to in the meetings.
- Please reach out to DIR/DWC/Governor's Office on this issue and demand that DWC honor the agreement made in the stakeholder meetings.

Meera Jani, D.C., Q.M.E. July 3, 2020

I am a QME. I have learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

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- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Jonathan Ng MD JD July 3, 2020

The proposed fee schedule is going to perpetuate the abuse of the system. The majority of orthopedic evaluations takes less than 2 hours to produce(face to face is less than 30 minutes). The proposed schedule pays $ 2000 for that.

The only equitable way to do this is to pay by the hour as in any other profession. The over reporting of hours can be controlled. The face to face time could be confirmed by the applicant. The pay per page reviewed is workable. The certification under perjury allows DWC going after abusers.

Instead of spending the time and energy of coming up with a complex scheme that pleases every stake holder, determine a flat rate per hour and spend time in getting rid of QMEs that inflate the bill.

Ali R. Berenji, MD July 3, 2020

As a concerned orthopedic surgery practitioner, with emphasis in treating the injured workers, I am also charged with important responsibility of functioning as a neutral Dr. (QME).

I consider the QME function extremely important in helping all parties to settle their differences. So the injured worker can proceed with his remaining productive life if he still has the ability. Even when he has lost some or majority of his abilities, I noticed many times that they strive to be functional again, in pursuing another job with his remaining abilities, I noticed unreasonable delays imposed on majority of these disputed injuries at work. The worker is not being provided the neutral evaluation (QME) on time.

In reality we need to encourage the QME to continue their important function, and not discourage them by trivial issues. I have no doubt If the QMEs quit, the system I believe will suffer immensely. By delay in solving the disputes, the insurance companies losses and costs will increase not decrease.

Despair and elongation of their disputes is not helpful. Their functionality need to be encouraged. In another word I have been proud and satisfied to see when I have been able to come up with justifiable resolution of the dispute in my reports, the worker compensation judges were able to solved the disputed claims really rapidly.

We all know in order to provide a high class service, the QME needs to be interested and believe in his role in the first place, in the second place he should also consider the worker comp. system could be burdened by UN-inhibited costs.

The recent dispute between QME provider groups, DWC, and payor groups, naturally, has impact on the future of all QME providers, including myself.

I noticed in the final stages of their deliberations their differences boiled down to relatively trivial things like charges on per page of records. In my own practice there have been many occasions that I have been provided voluminous records that were not all orthopedic. As an example in one case 11 thousand pages of records was sent, from that amount about 5-6 thousands pages were related to heart procedures, heart work up, heart F/U. I felt obligated to voluntarily discarded those heart records from my calculations for charges on the records. I have had many cases like that. I have done my own compromises to reduce the costs to the system silently up to now.

In contrary there are in some cases in which the records may not be as voluminous but due to complexity of the issues in question it may take a lot more time to address.

I am very hopeful all parties modify their demands so the issues can be solved by a compromise.

Kimberly Tangen PhD QME July 3, 2020
Licensed Psychologist

I am a QME in Psychology.

The flat-rate reimbursement for psychological evaluations under the proposed fee structure is well-below the current industry rates for Psychologists.

QME psychological examinations are required to meet the standards of the labor code and address various factors with respect to the injured worker's history.

These evaluations also vary in complexity based on the injured worker's history and the issues in dispute.

This means that the amount of time to complete a comprehensive psychological evaluation and write a medically-evidenced report that fully addresses these above issues varies for each case.

The proposed flat-fee schedule is well below the current industry rates for psychologists and does not take this into account.

A flat-fee that is well below the current rates will result in shoddy reports. This will adversely impacts the injured worker, the employer and the carrier.

Shoddy evaluations will result in poorly formulated opinions and treatment decisions.

The existing fee schedule was put in place in 2006. QMEs have not had a pay increase in the past 14 years. Many highly competent QME evaluators have left the system. The flat-rate reimbursement under the proposed fee schedule will result in more QMEs leaving the system.

I am asking you to revise the proposed fee structure so that Psychologist QMEs are fairly compensated for the time it takes to write reports that are in compliance with the requirements of the labor code. An hourly fee allows the compensation to be based on the unique factors with respect to each case.

H. Leon Brooks MD July 3, 2020

I am a QME and CSIMS Member. I have learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

Unfortunately (but not surprisingly given DWC's demonstrated track record of bias towards insurance company interests and against injured workers and medical providers), DWC violated the stakeholder agreements in order to favor the insurance carriers.

Specifically, DWC made the following changes against the stakeholders' wishes:

	DWC Stakeholder Meetings	**California DWC Proposal**
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Definition of re-evaluation	9 or 12 months	**24 months**
AME Modifier	1.25x and applies to **all services**	1.35x but applies **only to flat fee and not to depositions**
Medical records required to be sent 15 days prior to evaluation	Yes	**No**
Cover letter required to specify number of pages sent to doctor?	Yes	**No**
Automatic Annual COLA Increase?	DWC refused to hear this issue in the stakeholder meetings	**No**

DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee

- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation

- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.

- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.

- The mental health modifier should be increased to 3.0x

- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)

- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report

- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.
- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Anne C. Welty, MD July 3, 2020
QME/AME Psychiatry

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Unfortunately the DWC violated the stakeholder agreements in order to favor the insurance carriers.

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Automatic Annual COLA Increase?	DWC refused to hear this issue in the stakeholder meetings	**No**

I have heard that the DWC is <u>interested in and pays close attention to</u> the opinions of QMEs who are actually examining California's injured workers.

Please pay close attention to the bullet points below!

DWC should modify the fee schedule in the following specific ways:

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- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Portia Polner, Ph.D., QME July 3, 2020

I am responding to the proposed “Nevada” QME fee schedule that is open for comment. The proposed changes fail to incorporate the understanding of the DWC and stakeholders who previously met to discuss this issue. In the past 14 years there has not been a cost of living increase for QMEs, yet the cost of living has increased in California, one of the most expensive states to live and work. The cost of living including housing is significantly cheaper in Nevada. That is why Californians who can no longer continue to afford living here relocate there.

Lower feels for the same amount of work is tantamount to a decrease of already established fees. QME time to complete evaluations requires that we do not take short-cuts, but complete a thorough comprehensive evaluation. To not even compensate the time to review the first 200 pages of medical records by embedding that function in the flat fee further diminishes the process, especially in psychiatric evaluations which often are at a complex level. The omission of payment for medical research erodes the scientific process where the QME may need to further investigate a clinical area to render a medically probable judgment. Some cases, given their level of complexity may require additional face to face tome which will not be reimbursed. Applicants who require an interpreter need more time to complete an interview. Applicants who are depressed or anxious during the evaluation often require more time to complete the interview. These are realities that cannot be ignored in psychiatric evaluations. Nor should that extra time be dismissed as not justified.

As a QME since 1994 I find these proposed regulations to devalue the experience and expertise demonstrated when I have rendered services to injured workers for more than 25 years. The DWC runs the risk of losing long-term QMEs with such a set back. Although I have renewed my QME status for two more years. In the event that these proposed changes are approved, I will make my statement by dropping my QME status at the next renewal.

Anonymous July 3, 2020

I am a QME and CSIMS Member. I have learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

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- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- The mental health modifier should be increased to 3.0x
- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)
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Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

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- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Tanya Mesirow, Psy.D. July 3, 2020
Clinical Psychologist

I am a QME in Psychology. I am disappointed with the proposed DWC's WC fees. These new fees will make it very difficult to do a thorough QME evaluation in Psychology.

I am urging the DWC to modify the fee schedule in the following specific ways:

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- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
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Jeremy Blank, PsyD, QME July 3, 2020

I am a clinical psychologist and neuropsychologist and recently became a QME. From my review of the proposed MLFS, it is woefully inadequate for mental health practitioners such as myself. While DWC likely cannot undo its mistake of removing the

neuropsychologist designation from the books, they can act now to make the new MLFS a fair and equitable document.

First, regarding flat-rate reimbursement for cases. This assumes that all cases across all specialties take the same amount of time. In fact, psychological and psychiatric cases take far longer face-to-face and are often highly complex to write up. Moreover, in my subspecialty of neuropsychology, it is not uncommon to spend 5-6 hours face to face with an individual, the time being composed of in-depth assessment as well as detailed clinical interview. Thus, for individuals like myself to have a "fair shake" at things, the psych modifier needs to be 3x rather than the proposed 1.5x.

Furthermore, psychological and psychiatric records are often very dense and require much more time to review than other types of records. Thus, the psych modifier of 3x must apply to medical record review as well.

Additionally, there needs to be consistency in the per-page reimbursement for record review. Just because the number of pages goes over 2000 doesn't mean it takes any less time to review those records. The rate for record review should be fixed for all pages reviewed rather than reducing down significantly for all pages after 2000.

My final area of criticism for the proposed MLFS is that it does not stipulate for a COLA increase. As DWC is aware, there has been no reimbursement increase since 2006 for QMEs. And with the extremely high costs of living in the Bay Area, Los Angeles, and San Diego, it is only right to be afforded a COLA. Otherwise, DWC will be right back where they are in 5 years.

Despite my many reservations about the proposed MLFS, there are several improvements that are notable and should be kept, those being reimbursement for missed/late cancellation appointments and improved reimbursement for deposition testimony and preparation.

Thank you for your attention to my comments and the comments of others.

George Balfour MD July 3, 2020
Orthopedic Surgery & Surgery of the Hand Sherman Oaks
Past President CSIMS
Former member of the Board, California Orthopedic Association

A few years ago, I was having a conversation with Brad Sherman, congressman from Sherman Oaks. I asked the Congressman if he would be interested in a job that paid

one third of the 1993 salary and only have to work twice as much to earn it. The Congressman declined but that describes well California Medicine.

Since 1993 physician's income have fallen by 60%. The Division recently hired a consultant who advised increasing the fees for Medical Legal evaluations. The division held a stakeholders meeting and the parties came to an agreement. Yet the most recent proposal from the division as to a new fee schedule actually represents a further cut. If the Division is supposed to be a neutral party between stakeholders, why does, CSIMs has pointed out,that the numbers of QME requests over the past decade has more than doubled. Over the same period the number of physicians doing QME evaluations has declined by more than half. In any other marketplace that would lead to an increase in prices (fees) but not in California workers compensation where the division ignores basic economics and further lowers fees.

If the division actually looked at the demographics of the QME population, the division might discover a very elderly group. That means the likely hood of further lack of QME access is certain as that elderly group retires or dies.

I would suggest that the numbers of younger physicians doing Med legal evaluation is small. New QMEs do not represent replacement number for those QMEs leaving the system. You might be surprised to learn that doing adequate QME evaluations and reports is a skill that takes time to be acquired. Having inadequate numbers of trained QME evaluators is a recipe for lower quality and in the long run greater expense to the insurance industry. Surprisingly quality comes at a higher cost but ultimately saves money.

Unless the goal of the division is to destroy the Legislature's enacted QME process the presently proposed fee schedule is ill advised, and just plain wrong, Are you trying to subvert existing law by sabotaging the fee schedule?

I hope you understand this letter is in opposition to the proposed Medical Legal fee schedule.

Jed Sussman, Ph.D. July 3, 2020

I carefully read the latest proposal for med-legal evaluations within the California Workers' Compensation System. It falls short of what is necessary for me to continue to do medical-legal evaluations. Having 30+ years of experience doing psychological and neuropsychological evaluations for workers' compensations patients I can tell you the rate of pay for the amount of work and the complexity of work is far too little. As I am unwilling to compromise the quality of work needed to do such evaluations if the rate of

pay is not substantially increased, I will no longer do medical-legal evaluations. Nearly all of my colleagues feel the same way and plan on discontinuing medical-legal evaluations if the proposed rate schedule goes through. With fewer and fewer psychologists and neuropsychologists doing med-legal work, the system will back up further and add to the cost or processing claims. This in combination with evaluations being delayed due to the pandemic will further cause the system to back-up with respect to obtaining psychological and neuropsychological evaluations. I suggest, therefore, that you revise your rate proposal and offer one that accurately matches the complexity and length of med-legal work needed.

Ron Perelman July 3, 2020

A good start but there are some problems. Follow-up visits should be WITHIN 9 months not AFTER 2 years. Record review should be $3/ page PERIOD not up to 1800 pages AME fees at 1.35/1.45 should be based on total not just the eval. That is how it always has been. All records must be received in order with a page count so there is no billing dispute. The defense must get records to the doctors 2 weeks in advance or the doctor has the right to reschedule the exam. Otherwise the exam will not be accurate. Record review after the exam is double work and less accurate. Questions may arise from records and the doctor can’t ask the patient later on.

If the DWC can’t be neutral, hire a mediator to allow the providers and the carriers to agree to their own plan. Then DWC can write the regulations.

Stacy Hoyt, Ph.D. July 3, 2020
Clinical Psychologist

I am so saddened to learn of these proposed changes. Particularly as they relate to medical record review. I cannot tell you how many times I have had to inform applicants of a medical issue or concerns that were missed or they were not informed of. To further cheapen the good work done by QME's by nickel and diming professionals is beyond the pale. If you need to save money, let's direct our attention to the deep pockets of the insurance companies who continue to make a mockery of the process through games they routinely play regarding authorization, paying for bills etc. Have you ever tried to get psychotropic medication paid for so that an applicant can take medication routinely, without interruption or the use of samples from their PTP? I challenge you to look into this. Really a broken piece of the system which the carriers routinely exploit.

There was a time when a significant amount of my practice was QME evaluations. It was so exhausting and cumbersome to deal with the carriers I essentially gave up. I now perform maybe four evaluations per year. Our rates are so far below other forensic evaluations and the gymnastics needed to deal with the carriers makes it an ordeal I frankly avoid. I really enjoy the applicants, these evaluations and thus I allow myself to commit to a few per year. These changes, should they take place, will be the death nail for myself and I can only anticipate that I will not be alone. You have very few qualified, interested professionals currently performing QME evaluations, why further alienate them? Disaster.

I hope you will focus on meaningful change, rather than quibbling over mere pennies.

Anonymous July 2, 2020

Case 1

A 45-year-old patient comes to the office for a QME evaluation. The patient suffered from a shoulder injury at work. He is claiming that before the injury, he was harassed, and that the shoulder injury was an excuse to fire him. He has a QME scheduled for an orthopedic provider and a QME scheduled for a psych provider. The patient has 200 pages of records. The records consist of 100 pages of deposition, 40 pages of witness statements and 60 pages of medical records.

The orthopedic QME is able to do a 1-hour history and exam and go through 200 pages at a rate of 100 pages an hour and compose a report in 3 hours. So that is 5 hours of work. The QME will get paid 2015 dollars under the new schedule. That amounts to 403 dollars an hour.

The psych QME has to do a 4 hour history, it takes 6 hours to go through the records because the harassment issue is complicated, and it takes the psych 10 hours to prepare a report because the history is complicated, there are multiple discrepancies, and a Rolda Analysis must be done. So this is a 20-hour case. This psych QME gets 3022.5 dollars because of the 1.5 multiplier. The hourly rate for the psych provider is 151.13 dollars

So the orthopedic doctor made substantially more on the orthopedic claim, per hour, than the psych who had a much more complicated analysis.

Both doctors now get deposed.

The orthopedic doctor prepares 1 hour for the case and is deposed for one hour. The deposition fee is 455 dollars and hour, so that doctor gets, 910 dollars. The effective hourly rate is 455 dollars.

The psych doctor has to prepare for 4 hours because of the complexity of the case and gets deposed for one hour. Because the DWC has historically only allowed 2 hours to be paid, the QME will get a total of 910 dollar with the effective hourly rate of 182 dollars.

That same patient has an ortho surgery and develops MRSA. The patient sees a psych for 8 sessions of treatment. There are now 200 new pages of records. The patient lost their house, got a divorce, and now faces the prospect of never being able to return to work. The patient is referred for a re-evaluation with the psych and the ortho QMEs.

The ortho QME spends the same amount of time as the original examination and gets 1316.25. This QME will get 263.25 dollars.

The psych QME has detected a significant emotional worsening after MRSA and it takes 2 hours to talk to the patient, 4 hours to go through the records because now the records include mental health evaluations and treatment. The report requires 6 hours to compose. So that is 12 hours. With the psych multiplier, that is 1974.38 dollars. That is essentially 164.54 dollars per hour.

Case 2

A patient is scheduled for a QME with a pain management doctor and a psych doctor.

The pain management doctor reserved 1 hour of time to evaluate the patient for a QME but the patient did not show. That pain management doctor gets 503.75 dollars for that one hour.

The psych doctor had to reserve 8 hours to see the patient because of the need to interview and to testing. The patient does not show, and the psych doctor only gets 503.75 dollars, or 62.97 dollars per hour.

In each of these cases, the inequity for psych evaluations is apparent. The DWC is proposing to severely cut reimbursements to psych providers under this proposed schedule. This is clearly does not make sense economically for psych providers. This shows how the stakeholder failed to seriously psych QMEs and the patients that see them. This schedule must be totally rejected.

For any non-psych QME that does complicated evaluations, you will face the same severe economic penalties, but you won't have the benefit of the multiplier unless you are a toxicologist or an oncologist. The DWC is essentially proposing to harm your

practices. Even providers in lower cost Nevada get much more respect. The DWC also failed to give the increase in rates as recommended by the auditor for both psych QMEs and QMEs providing complicated evaluations.

Dr. Deborah Chen July 2, 2020

I am a QME have learned that provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

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Medical records required to be sent 15 days prior to evaluation	Yes	**No**

	DWC Stakeholder Meetings	California DWC Proposal
Cover letter required to specify number of pages sent to doctor?	Yes	**No**
Automatic Annual COLA Increase?	DWC refused to hear this issue in the stakeholder meetings	**No**

QMEs already told DWC in 2018 and 2019 that they want the Sue Honor fee schedule which has over 2,750 signature in support. Why does the DWC continue to ignore Sue Honor's proposal?

At a minimum, DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- The mental health modifier should be increased to 3.0x

- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)

- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report

- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.

- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

James E. O'Brien, M.D. July 2, 2020

If you want to discourage lengthy, expensive reports, RAISE the charges after 500 or 1000 pages and the parties will have an incentive to stop with the document drops. This is not impossible as many insist. A paralegal can eliminate the duplicates and the unnecessary content-free pages that the QME never needs to see in the first place. Believe me, records get more difficult and time consuming the longer they go on. For perspective, remember that a King James Bible is 1200 pages, so the fatigue factor at 2000 is severe.

The COLA increase is inadequate and will not account for inflation going forward, which is going to be seventies-like with these massive budget debts. There has been at least a 50% increase in the cost of living in CA in the past 15 years and far greater if you factor in housing and food and the other stuff that the official fake numbers conveniently leave out. It goes without saying that it is more expensive to be a doctor in CA than NV.

Elizabeth Wantuch, Psy.D. July 2, 2020
Clinical Psychologist

I am a QME/psychologist, and I'm very concerned about the proposed new QME fee schedule for psychologists and psychiatrists. What you are proposing is completely untenable.

The nature of a psychologist/QME report is very different than that of an orthopedist, chiropractor, or any other medical specialty. For example, I typically spend three hours on an initial interview to get an adequate history and understanding of the applicant's claim. What you propose would allow me to spend only an hour, which is wholly inadequate. Making sense of the interview, analyzing the applicant's test results and medical records, and putting the pieces together into a report that explains what is going on with the applicant is a complex puzzle that requires many more hours than your flat fee allows for. As another example, the number of pages in medical records is meaningless for a psychologist's report—unlike that for other medical specialties. Quite often, there is little in the way of records that is germane to understanding a case from a psychological standpoint. So being paid for reading X number of pages is a meaningless basis on which to pay a psychologist/QME. Similarly, every supplemental report is unique and requires a different amount of time. It may require as little as 15 minutes or as much as two or more hours, depending on the case.

Frankly, any fee structure for psychologists or psychiatrists needs to be based on the complexity of the case. Complexity determines the number of hours spent on the report. A fee structure which is based on time is fair, in my opinion. If you feel that someone is abusing that structure and overbilling, then punish the offender, not the entire profession.

Lastly, it is very curious to me that the DWC would look to reduce a psychologist's fee at a time when you need more psychologist QME's to handle more psych claims and more complex claims. In my nine years experience as a QME, I believe the cases we are handling are becoming more complex. With Covid-19, I would expect to see a huge increase in cases in the near future. If you are looking to increase the quality of psych reports, you should be looking at some sort of education and/or licensing requirement. What you are now proposing will reduce the overall number of QME's and will certainly eliminate the best psych QME's!

I thank you for your attention and hope that you will take into consideration not only my comments but the expert opinions of the CSIMS board members with whom you have been talking. It is very disappointing and disheartening to learn that the many hours they have spent with you has resulted in such a poor current proposal.

Arsalan Malik, MD
Private Practice of Psychiatry
Diplomate, American Board of Psychiatry and Neurology
Diplomate, American Board of Integrative and Holistic Medicine
Clinical Associate, New Center For Psychoanalysis
Clinical Instructor, UCLA Department of Psychiatry
Qualified Medical Examiner

July 2, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

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The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Barry A. Halote, Ph.D., QME July 2, 2020

I have been a Qualified Medical Evaluator (QME) since its inception. I have weathered good times, bad times, throughout this process. I was just presented with the new fee schedule. I find it reprehensible that after not having a fee increase after approximately 11 years, you would propose a decrease. I am a psychologist, and reports can take up to 20 hours when medical records (200 pages), face-to-face time, and report preparation are combined. You arrived at a fee schedule of approximately $3000 for a psychological report, that includes 200 pages of medical record review, resulting in an hourly rate of approximately $150. **This is a 40% from a fee schedule that is approximately 11 years old and has never accounted for inflation.**

There comes a point, that performing an evaluation with care and understanding, is not worth the time and energy when you are not receiving appropriately reimbursed for the effort and expertise it takes to complete a QME report that is substantial medical evidence. **Therefore, if this fee schedule does come to fruition, I will have no choice but to surrender my QME because it is not financially feasible to continue in the system.**

To my understanding, there have been many meetings between stakeholders regarding this fee schedule, and they came up with a consensus. The one presented for consideration at this time, has numerous changes, all to the detriment of physicians, even though the payers agreed that they were appropriate. Why this was done, begs a lot of questions that will not be addressed here.

What this fee schedule tells me is that the Department of Industrial Relations does not consider my profession important. I have spent numerous hours and effort in educational endeavors that would enable me to navigate the complex world of medical legal report writing in the arena of workers compensation that would result in a report that is substantial medical evidence. **I see this fee schedule as a slap in the face**.

Anonymous July 2, 2020

In my opinion there is more good than bad in your proposal. I am a psychologist.

The problems as I see them (in no particular order)

1. I do not think it fair to charge a different fee for record reviews of greater than 2000 pages. (2$ vs $3 for pages 201 to 2000). It takes the same amount of time to read each page.
2. I would strongly suggest insurance company count the pages of records sent. I believe this will open the door to page fraud count by some providers.
3. I believe a cost of living increase would be a good decision. The medical fees for treatment is adjusted . I believe this will help retain QME providers.
4. I believe the no show fee for a psychologist should be 50% higher than general as we have to set aside more time for the appointment than our medical peers.
5. I think failure of defense to provide an interpreter should allow the provider to collect a no show fee. This is not mentioned.
6. Problem of some specialties being underrepresented.
   If There is a discrepancy in the number of QMEs per exam among the different specialties.. I would consider the following formula to adjust:
   Total number of QME exams for a specialty divided by the number of QME doctors in that specialty.
   That will provide a baseline for fee adjustment. Those specialties without enough doctors per exam should be paid more. Increase the fee and you increase supply of doctors for that specialty. To make this more cost neutral, those specialties significantly over represented might receive a fee reduction. If you reduce the fee you reduce the supply. This data could be adjusted every X(2,3,or 5) years.
7. The fees for psychologists should be slightly higher than 1.5. Perhaps 1.75 to 2.0. The current proposed fee is not really an increase for psychologists. However, one should keep in mind the relative abundance of psych QMEs. To reduce the supply, reduce the fee. So maybe this fee may be reasonable from the supply/demand perspective.

Medical Legal Fee Schedule Forum Comments

Richard F. Geist, MD July 2, 2020

First I'd like to say how pleased I am that the DWC has undertaken a thorough review of problems with the current QME physician reimbursement system. I am an internist who just 2 months ago resigned my active QME status. Even though I am currently inactive I believe that my comments remain worthy of consideration. My real concern is for California's injured workers who will have progressively more difficulty obtaining quality care and an appropriate & timely settlement, as these new regulations will continue to reduce the ranks of participating QMEs.

It is my understanding that since the last **Reimbursement update 14 years ago**, that the number of QMEs has declined by 50% while the number of cases requesting QMEs has increased 50%. This proposed fee schedule's problems are guaranteed to drive away more QMEs, diminish the number of new QMEs and reduce the care injured workers get.

Excellent changes include the ability to bill for Record Review time even when a worker misses an appointment. It was also nice to see the inclusion of travel time in Medical-Legal Testimony and an 8 day deposition-cancelation cutoff (although that would be better worded as 8 working days). When interpreters fail to appear we should also be allowed to bill for the Record Review that we have done.

However a number of the proposed changes are EXTREMELY PROBLEMATIC!

1. I am very disappointed that these proposed fee schedule and rules contradicts agreements between participants in the multi-sided, Stake-Holders meetings earlier this year, and the agreements hammered-out between insurers and providers. Suzanne Honor's well-accepted proposed update (https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal) and a general agreement that fees should increase 30% to account for 14 years of unchanged rates have also been ignored. This action tears at physicians' trust in the DWC and the fabric of injured worker care.

2. Propoaing a reimbursement scale BELOW that of neighboring Nevada makes absolutely no sense.

3. **Not building in a Cost of Living annual increase degrades the value of our time and energy each year.** Judging from the most recent 14 year gap since the last time there were any fee revisions, QMEs can expect another 50% - 70% devaluation of their time before the next revision.

4. Most of my cases involve medical questions on primarily orthopedic cases. Often these workers have not seen a generalist for many years, vital signs are frequently absent from the notes, and no internal medicine issues have ever been addressed,

much less any pertinent tests ordered. In essence I am starting from scratch on the evaluations. Not infrequently simple baseline medical testing reveals a potentially work-related problem that then requires additional testing.

5. I frequently receive no old records documenting findings from BEFORE the Date of Injury or the start of the Cumulative Trauma claim, as well as absolutely no records that address any Internal Medicine issues. Thus my initial report is often starting from scratch, and the need for literature research only becomes apparent at the time a Supplemental report is being prepared. This is not taken into account under (m) Supplemental medical-legal evaluation. And even a first Supplemental report often requires an second Supplemental report because of information that was sent late or insurers' frequent behavior of taking months to obtain diagnostic tests.

6. The medical records sent to me frequently contain 2,000 to 5,000 pages. It is unreasonable to pay less for me to review pages 1801 to infinity (or elsewhere 1950 - infinity) than for the first 1,800 (or 1950) pages. In fact the proposed fee schedule for record review represents a payment far less than the suggested 30% reimbursement that was suggested and agreed upon in the Stake Holder deliberations. Another problem is that these thousands of pages of records frequently arrive only 3-4 days before the scheduled QME evaluation. It is not always possible to complete a detailed review within that short period, and thus it is unreasonable to limit payment for these record reviews to the initial billing rather than a supplemental report.

7. ZERO payment for addressing an issue. The title of this section as "Remedial Supplemental Medical-Legal Evaluations" is prima facie insulting. I already typically get boiler plate introductory letters from insurers or many attorneys that contain multiple paragraphs of irrelevant questions. Will the insurers simply expand their questions to cover every conceivable question, and then screw us for not having addressed one of the irrelevant questions? I also frequently receive NO introductory letters or letters that have absolutely no information concerning the particular case. It would be far more appropriate to limit such a demand for FREE WORK to reports that initially fail to constitute "Substantial Medical Evidence" because they miss regulation-required information (8 CCR §10606).

8. Records should arrive at the time that the QME interview is scheduled. "Duplicate records" must be reviewed just as carefully as initial records. If one batch contains 1500 pages and the other batch 1750 pages, the ONLY way to be certain that I have reviewed and picked up ALL the information in the submitted records is to go through BOTH sets of records page by page (and mind you they will not be in the same order)!

9. Extending the period of Follow-up Medical Legal Evaluations from the current 9 months to your proposed 24 months is simply unreasonable from a clinical point of view

By 12 months most cases require a complete re-evaluation and should be compensated appropriately.

10. A special increased reimbursement rate for Toxicology and Medical Oncology is proposed. WHY? If scarcity is the issue, there are also few California QME in other specialties: Cardiologists, Nephrologists, Hematologists, Gastroenterologists, and Thoracic Surgeons for example.

11. I urge you to return to this proposal, correct the figures and situations that had been hammered out by the Stake Holders, and the Suzanne Honor's proposed update and rewrite a more complete and fair proposal that acknowledges that a win-win must happen for insurers, physicians, and attorneys if excellent care for California's injured workers is the desired outcome.

Marshal S. Lewis, MD July 2, 2020

I am a California licensed orthopedic surgeon who has performed Qualified Medical Evaluations for over 20 years and the following are my comments regarding the proposed amendments to the Medical-Legal Fee Schedule.

The Newsline 2020-56 dated June 25, 2020 is accepting comments until 5 p.m. on Friday, July 10, 2020. This is RIDICULOUS. This is not only during a holiday week (4th of July) but only gives 15 calendar days to respond. If you calculate the holiday which represents the birth of American independence and is widely celebrated we only get 14 days. If you calculate in business days you only get 10 days to respond. This timeframe given is minimal. I guess it could have been worse. The proposal could have been dated December 25 with comments accepted by Jan 10, 2021.

During the numerous stakeholder meetings that you claim were held between carriers, employers, medical management companies, and physicians gathered for discussion of this proposal why were they not done as an open forum with the California QME physician who are performing these evaluations? Possibly over the internet. If I was a physician that was asked to attend these meetings to change a fee schedule that was going to affect all QME physicians I sure would want to make sure this was in the best interest of all physicians performing these evaluations. Capitation has never worked successfully for physicians to the best of my knowledge. Usually the amount of work far exceeds the reimbursement in most capitation systems as far as the physician is concerned.

The Missed Appointment fee of$503.75 is inadequate. The physician books out

substantial time for these evaluations and for a reimbursement of $2,015 for an initial evaluation. The physician has to review the amount of records which are often substantial and has to allow the appropriate amount of time for the evaluation and preparation of the report. Now you want to reimburse the physician 25% of the amount of an initial evaluation if the appointment is missed. Certainly the physicians expenses and preparation time of the review of records have not decreased by 75%. The missed appointment fee should be the same as the initial evaluation fee. It currently states that a scheduled appointment shall not be cancelled less than six business days prior to the appointment. When a cancellation is received there is not enough time for a physician to place another Qualified Medical Evaluation in that slot.

It is incomprehensible to me how it is proposed for the physicians to provide 200 pgs. of FREE record review for each exam. The proposed flat rates of$2,015.00 for a Comprehensive Medical-Legal Fee and $1,316.25 for a Follow-up Medical-Legal Evaluation is also one-sided and in favor of the insurance carriers and employers. The flat fee seems like a lot of money, except if you have an individual who does not speak English and a certified interpreter is utilized. The histories alone sometimes take 2 to 2 1/2 hours for me to do. I try to dig into the patient's history and find out what happened and what is going on. As you know, the interpreter has to interpret and translate the medical information between the physician and the patient. This is sometimes a very lengthy process and sometimes the answers are somewhat evasive and I have to repeat some of the questions multiple times. It is felt that an hourly rate is the most appropriate for the Medical-Legal evaluations and keeps the system as honest as possible. Follow-Up Medical-Legal evaluations sometimes take an inordinate amount of time and certainly the flat fee of $1,316.25 is totally inappropriate if one has to review an inordinate amount of medical records. It is not uncommon for these follow-up evaluations to come with a new stack of medical records that have to be reviewed, discussed and dictated. It is further noted that your proposal for the no reimbursement for review of records within a twenty-four months is inappropriate. It currently states no reimbursement for further review of prior medical records within nine months and that is difficult enough.

Certainly to expect the physician to recall information greater than nine months and less than twenty-four months for no reimbursement is inappropriate and is difficult for this orthopedic surgeon to understand why you feel this is fair an appropriate. The fact that you expect the physician to remember and discuss the items in the history and physical more than nine months old is inappropriate and without the physician having the ability to spend the time to further reevaluate that previous information in conjunction with the case.

It is not uncommon that I get hundreds of pages of medical records to review for an

initial case. I have to know what is on pg. 9 when I get to pg. 625. I am constantly making side notes throughout my review of the records and flipping back and forth between pgs. to determine various findings. The review of records should be reimbursed at an hourly rate and in no way should the review of records be included in a flat fee for a Medical-Legal evaluation. I feel that not only do the records have to be read and understood, but they also have to be dictated as part of the report. I think it is extremely important that if you are looking for a price per page the rate should be an adequate amount. The rate per page should be expensive enough for the carrier that they will want to send just the records they need to be reviewed rather than sending disorganized and incorrect records of other individuals which happen frequently and usually arrive 1-2 days prior to the evaluation. I doubt whether any attorney or other business professional can afford to review records at $3.00 per page. It is an enigma to this orthopedic surgeon why records above 1800 pages are reimbursed at $1.00 less per page instead of a higher rate since it becomes more complicated when the number of records is greater than 1800 pages. It would be harder to correlate the records below the 1800 pages with the records above the 1800 pages. I would like to know what the concept of the lower rate was based on since it doesn't make sense to this orthopedic surgeon.

These new rates do not account for the preparation of the report which includes the physicians review of the report and transcription of the report. There was no mention of a rate for the medical research. These seem to have been omitted from the new proposal but were included in the prior Medical Legal Fee Schedule. Why have these been omitted as the costs for doing business as physicians have gone up and not down.

There is already a shortage of QME physicians in the State of California and a decrease of some specialty QME physicians. Due to the QME unavailability the injured workers access to benefits is delayed. I fear that if the DWC goes to these flat rates they are probably going to lose a substantial amount of QME's as it will not be profitable for the physicians to see these patients. The doctors may not realize it initially, but they will realize it very fast when they see what their expenses are. The office costs money to operate which include rent, equipment costs, gas and elec1rio, phones, and typists. The reports have to be proofed and sent out to multiple entities, which requires duplicate copying and postage.

Alec Koo, MD, Urology QME July 2, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting,

AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

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This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Robert J. Tomaszewski, Ph.D., ABPP-CN July 2, 2020
Board Certified in Clinical Neuropsychology

Above all else, it is injured workers who suffer the consequences of inadequate or delayed evaluations in the workers compensation system. Retaining qualified medical and psychological providers involved in the workers compensation system is essential to providing quality oversight of the care and determining the complex medical legal issues. Since 1994 the effort to develop QME criteria and continuing education has helped but the difficulties with payment for the excessive amount of work entailed has resulted in far fewer respected colleagues remaining involved in the workers compensation system. Please consider the reasonable proposal for Susan Honor

https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

I urge DWC to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Jill Torres, QME July 2, 2020
Psychologist

I am a psychologist and QME. I am writing to indicate that I believe the proposed new fees are very inadequate.

Using a flat rate of $325 as was recommended by the auditors if we are allowed $3022 for an initial QME with two hours of records this essentially means that we are being paid to complete all aspects of the report including face to face, formulation, writing, Editing, and Up to 2 hours of record Review (considering 100 pages per hour) in. 9.25 hours. If the records take 2 hours that leaves 7.25 hours for everything else. This is very inadequate. Most QME face to face for psych is about 4 hours leaving only 3.25 hours for the formulation, dictation, and editing of the reports. As you are aware most psych reports are quite complex and frequently Require a rolda analysis, which itself can take up to two hours. Then the issue of apportionment can also take a significant amount of time. I believe that a modifier of 2.0 would resolve this issue and account for the added time and complexity required.

Next, the idea that a re-evaluation 23 months after the initial evaluation should be paid significantly less is unreasonable. So much transpired during that time frame. A reduced fee for a re-evaluation up to 9 months is reasonable. This typically will allow the person to get any recommended treatment and hopefully provide a P&S report.

Third, the way I interpret the proposal records that are submitted any time up to the day the report is issued (up to 30 days after eval) should be included in the initial evaluation and we cannot bill them as a supplemental report. It is unreasonable to expect a QME that receives the records more than one week after the exam to incorporate the records into the initial QME report. The records really should be provided in advance of the exam do the doctor can review them before the eval. I simply could not add a records review and commentary and possibly change my entire options within a few days of records (often very large volumes) are provided 10-30 days after the evaluation.

Fourth, the idea that if the parties believe an issue should have been addressed and was not in the initial QME report that we should have to issue a supplemental report for free is unfair. Nobody in this field works for free. If it is. Something that was egregiously

left out of the report or completely ignored from the cover letter questions that might be acceptable however this should be a rare circumstance. If it is occurring frequently the physician should be disciplined by the DWC. As it stands now the attorneys would subjectively be able to deem that we should have addressed something and demand a free report and if we refuse we would face discipline. If there is a reason to request a free supplemental for an issue not addressed the request should be titled ‘Request for unpaid Supplemental Report” and there needs to be a mechanism to dispute this expediently with the DWC.

Fifth, page count needs to be better defined. In the medical industry the standard is letter size with hand written notes or 12pt font single spaced with double spacing between paragraphs and headings. As of now the proposal would allow legal Size records that are 27% more to a page and could be submitted in any font size. This could lead to abuse with single space legal size 8 or 10 point don’t records in order to keep page count down.

Sixth, the party sending the records needs to be responsible for verifying and certifying the page count and organizing records coherently and with an index either arranged by provider or chronologically and on single sided paper. Very often we get records that are simply a mess and it can take hours to organize them before they can even be reviewed.

Please seriously consider these issues. As it stands now the proposal is extremely unfair and it will lead to so many unforeseen conflicts and disputed because many terms and issues are not well defined.

Michael Blott, D.C. July 2, 2020

Many will share with you why there should be increased payment.

I would like to take this time to request enforcement that payment be made.

As an instructor of dwindling QME instruction classes, I can tell you a major reason QMEs are leaving practice is lack of payment at all. We are left using the WCAB as a collection agency which is not worth the effort.

The DWC claims there is no problem in QMEs getting paid but at the same time created the NON-IBR petition and no fees for QMEs to use the WCAB. The petition process is tedious and if there is an appearance (up to 5 times if the defense does not appear) the cost in time is nowhere near the cost of QME income.

Let me be clear. There is no dispute as to what is to be paid but if any payment or Explanation of Review be made.

I suggest the DWC Audit Unit investigate all QME complaints for billing not paid within 6 months.

Currently, they investigate claims on a random basis and do not investigate non-payment of QME fees other than late payment penalties.

Penalties to the State described in Chapter 4.5 Division of Workers compensation subchapter 1.5 Article 1 should more than adequately cover costs.

Brian C. Bashner MD FACS FAAOS July 2, 2020

I support the new workers compensation QME fee schedule as presented to the membership of the California Orthopedic Association. It is clear, straightforward and prevents the criminalization of qualified medical evaluators.

Additionally, there must be certain (employer-carrier) regulations which prevent abuse of the QME. These regulations would keep costs down, improve efficiency and minimize requests for additional information.

1. Four weeks prior to the examination, the qualified medical evaluator must receive a letter describing what medical legal issues are being disputed. The letter shall state the specific labor code 4060, 4061 and 4062 as well is described the specific medical-legal dispute/objection and clearly identify the need for the QME .When the applicant is represented, the correspondence must be a joint letter from the defense and applicant attorneys.

2. A clean copy of records with no duplicates in chronological order must be sent to the qualified medical examiner four weeks before the mutually accepted date of the examination. This should be in a PDF format which can be opened by any standard software.

The reason for these two regulations should be abundantly clear. it should not be the responsibility of the highly trained physicians/QME to be performing unnecessary administrative work. There are services that will do this for the carrier/employer.

The qualified medical evaluator has limited time to complete an accurate report and send it to the appropriate parties. If we are able to review records prior to seeing the patient, and if we understand beforehand what the medical legal disputes are, we are

able to present a complete report more quickly and accurately. This will benefit all parties.

These additional regulations are simple and logical. The regulations I propose shall result in lower overall costs and significantly improved accuracy and timeliness of reports. They will prevent many follow-up re-evaluations, and failure of the evaluator to completely address the disputed medical legal issues presented in the joint letter.

Anonymous July 2, 2020

I am a QME in psychiatry writing in response to the proposed changes in the medical legal fee schedule. The persistent message that is being sent by the administration through this schedule and all the preceding efforts over the past 5 years is that QMEs are grossly overcompensated. This is happening while the total expenditures on medical legal exams have not changed in 10 years and the number of panel requests during the same period of time has doubled. Obviously the administration is aware of this fact as the data is as available to them as it is to me and more so. So the only conclusion that can be reached with this level of consistency in the administration's behavior is the aim is to cut compensation to QMEs at any cost and hope that at some point there will be no uproar and the regulations will go through.

I do my own work, all of it: record review, interview, report writing. The average number of pages sent for record review is 5-600 per case. Under the proposed schedule I would be compensated 1200 for the 400 and the rest would be covered by the flat fee. I would like those who propose this to consider how much time it would take them to read their favorite novel while summarizing it. 100 pages an hour? I don't think so. The fact that the administration makes no differentiation between a psychiatrist needing to review in detail many records looking for clues of behavioral disturbance, while a dentist needs to only know some basic facts and diagnoses is truly unconscionable, especially as the standard for the report is still being held as substantial medical evidence. I have been rigorously questioned by defense attorneys on the manner in which the claimant filled out a pain diagram when seeing an acupuncturist!!!! That is the level of scrutiny of the reports! I should have said that the directorate of the DWC does not want me to spend much time on these trivial matters and that defense should address their questions to the directorate instead.

If we consider the flat fee for the psychiatric evaluation, the $3000, which at the present rates would represent 12 hours of work without any raise from 2006 levels. If the proposed payment for deposition is actually more of an indication of the value of an expert's time, the fee would represent around 8 hours of time. Well, let's see. The patient is seen for 2-3 hours depending on their ability to give a psychiatric history

cogently, and on occasion for 4 hours; the 200 pages included would take me an average of about 3 hours and report dictation and considerations of conclusions which include the Rolda analysis and apportionment would take about 9-10 hours. So 14-16 hours of work compensated at level below those of 2006, at $200 per hour.

I would like to know under what circumstances anyone working for the agency takes a 20% pay cut on a permanent basis? Please provide some examples. It likely could not even be done without formal demotion. If that is the idea, perhaps the directorate can also rethink the role of the QME as an expert. Perhaps we could be note takers with medical degrees with no responsibility for the conclusions or outcomes?

I have little doubt that fraud exists in the QME system, but if cutting compensation on those who work in good faith is reasonable, consider this: there is fraud in state government, lots of it. Maybe even in DWC! Let's cut the salaries and the budgets by 20% and see what happens? No?

James L. Deck, Ph.D., QME July 2, 2020

After working 33 years in this system, the proposed changes will destroy the quality of psychological/psychiatric evaluations which will grossly hurt Applicants and grossly benefit insurance carriers. An adequate evaluation cannot be done under the proposed changes. Ultimately, the saying,"You get what you pay for" will pertain.

Dr. L. J. Wolff July 2, 2020

Greetings, I am a 20+ year QME and must say that I am quite disappointed with the proposed DWC new fee schedule. This fee schedule disregards the hard work put forward by the stakeholders meeting. I'm strongly considering not renewing my QME license.

Robert D. Verrette, DPM, FACFAS, QME July 2, 2020

These changes to the QME schedule, may inhibit my ability to continue to practice in the worker's compensation system. Not only are these QME's arduous, taking a lot of time out of practice, but my original intent was to serve injured workers with dispute in this worker's compensation system. Unfortunately, due to the change in reimbursement, and if this is fee schedule is enacted, I will have to withdrawal my QME license that I have had since 2005.

Adam Kremen, PhD., QME July 2, 2020

I would like to comment on some aspects of the proposed revisions to the regulations for reimbursement for medical-legal expenses. I am a QME psychologist, and I speak here for psyche reports.

The proposed fee-schedule is woefully inadequate. It represents a significant pay cut, especially to psychologists and psychiatrists who are discharging their duty to provide complete and fair QME reports.

It is impossible to evaluate and write up a case that has any complexity, such as those routinely found in psyche cases post SB863, in anything less than 15 to 20 hours, while also doing any justice to the responsibility to produce balanced, probative reports that provide evidence that can be used by attorneys, unrepresented injured workers, claims administrators, and WCAB judges to move cases forward towards resolution. The DWC's own recommendations for an adequate psychological or psychiatric evaluation report, as stated in the "Method of Measurement of Psychiatric Disability", include a comprehensive evaluation of an applicant's history (including history of the illness, psychosocial history and history of previous psychiatric illness), symptoms, and current and pre-morbid psychological functioning, to name a few, as well as a review of medical records and objective testing. Given these suggestions and given the high likelihood that a psyche case will be complex, it is unlikely that report preparation will be less than 8 or 9 hours, and it is often the case that it will be more. On top of these hours for report preparation there is also the time spent in the interview (typically 3 to 4 hours; record review; and research if there are any special issues). Thus, one major problem with the proposed revision is that QME's who take the necessary time to write an adequate and legally useful report will be unfairly compensated.

It appears that the DWC is proposing to use number of pages of medical records as a stand in for complexity. \While this strategy might make sense for certain types of injuries, I have had several very complex cases in which medical records were minimal. In cases with direct psyche injuries, if the worker was not seen for mental health treatment, there will often be very few records; or even if seen, there are often less than 100 pages of medical records, especially since mental health treaters often submit summaries rather than individual session notes. And in complex cases with prior psychiatric history often the prior treatment notes are not submitted, or the applicant has never sought treatment in the first place. Yet diagnostically and from the standpoint of analyzing causation and apportionment issues, these cases are often very complex. Therefore, it is highly likely that psyche QME's will be presented with complex cases with few medical records, and in this way they will also be woefully underpaid.

A possible outcome of the onerous financial burdens imposed by the inadequate and unfair proposed revisions to the Medical-Legal Fee Schedule would be to force many highly qualified QME's to leave the system. Another possible outcome will be to pressure QME's to cut corners and thereby produce inadequate reports. Both of these outcomes will in all likelihood lead to additional inefficiencies in the system, clogging down the wheels of justice and paradoxically increasing the financial burden as many more supplemental reports and depositions will be required to make up for the inadequacies of the reports.

I strongly urge you to reconsider Sue Honor's proposal, which she submitted in December 2018.

Robert Armani July 2, 2020

Respectfully I like to comment on this important matter, as we all know the Worker's Comp's system is pretty much one-sided against the employees! We cannot get as a PTP approved one single MRI or x-ray or therapy and almost 90% of the cases are denied and litigated.

The QME doctors are the only barrier and only fair and balanced entity left to neutralize the one-sidedness that is in Favor of carriers.

Not only you should not cut the QME fees you should actually increase the fees.

As QME doctors we do a tremendous amount of hard work with our QME exam and report it is an arduous job, it's hard work, it takes a lot out of the doctor to sit there for hours and hours review records do research do reports be deposed on and on and come up with numbers and ratings and decisions, etc.

The fact of the matter is you should increase the fees and reward the QME doctors not reducing it.

Julie Armstrong RN Psy.D. QME July 2, 2020
Med-Legal Psychology Evaluations/Consultation

I am strongly opposed to the proposed changes to the current QME fee schedule.

There is no good reason to make these changes. The proposed fees will GREATLY REDUCE THE RATE PAID TO PSYCHOLOGY AND PSYCHIATRY QME DOCTORS.

The Labor Code requires an extremely comprehensive evaluation in accordance with 15 pages of guidelines about what must be evaluated. It is devaluing and unreasonable to expect that a comprehensive evaluation according to the Labor Code guidelines can be conducted for the proposed fees.

The result of this reduction in fees is likely to have at least 2 important consequences.

1. Good QME doctors will stop doing the work. Currently a similar evaluation n the civil litigation arena pays $500-800 per hour. Why would a good psychologist or psychiatrist bother?

2. The reports you get will be hurried, incomplete and inadequate to use as evidence. Case resolution will be delayed as supplemental reports will be required to clarity and justify opinions rendered.

3. Circumstances will be made worse as work related COVID cases start to enter the system, increasing the volume of cases requiring evaluation.

There is no obvious rationale for the need to revise fees at the present time. The RAND study - which the State of California requested - came to the conclusion that a fee **increase** was in order. QME doctors have not seen a fee increase since 2005. But doctors are not pushing for an increase. It would appear that the DWC is interfering in a process that it's unnecessary and unneeded at the present time. What is the rational for this proposed change? Are lobbyists involved? It sure seems so.

The proposed fee schedule seems to be in direct opposition to previously stated desires to engage in negotiations with the QME stakeholders. They rate proposed is devaluing and prohibitive. I cannot conduct an interview (min. 2 hrs alone), pay the office rent, pay for the psychological testing scoring, draft the opinions and edit and complete the report for the fees you are proposing. Psychology/Psychiatry evaluations are often in excess of 25 pages.

Please reconsider this proposal. It is unreasonable and untenable. The exodus will happen.

Ira Fishman MD, QME July 2, 2020

1. The regulations are ambiguously written with many unintended consequences that need clear clarification and considerable rewriting. Just two examples of many. "Page" needs a much more precise definition and should not include an 8.5 X 14-inch page. Definition of reevaluation for billing purposes should be 9 or 12 months not 24 months.

2. Reimbursement remains inadequate. Several examples. There should be no "volume discount" for MR review after 2000 pages. AME modifier should apply to all services including depositions and MR reviews. An oncology modifier should apply to all reports that primarily consider an allegation of industrial cancer (There are hardly any board-certified oncologists that serve as QMEs. The proposed rules as written would apply to only a minuscule fraction of internal medicine QMEs).

3. The DWC ignored many agreed-upon points from working groups containing evaluators and the insurance industry without exception to the evaluators' detriment. As a QME and member of CSIMS, I note that our organization perceives that the DWC Did Not Honor the QME Fee Schedule Stakeholder Process. That needs to be remedied by a total rewrite of the proposed regulations to reflect in its entirety what was agreed upon by payors and providers in the stakeholder meetings.

4. The DWC needs to acknowledge that there are complex cases out there that require special handling. The parties should have available at their joint agreement an opt-out mechanism from the proposed medical-legal billing schedule. Solely upon the parties' legal agreement, the evaluator should have available a billing code reflecting the use of medical research and the extended time required in formulating a complex medical-legal report, regardless of the number of medical record pages submitted. Not having such a mechanism in place is ultimately a marked detriment to severely injured workers and will serve to diminish the quality of reporting for complex cases.

5. The remedial report regulation proposal requires extensive rewriting and much more clarity. Evaluators need more protection from legal parties using legal strategies such as writing lengthy purpose letters crafted to provoke the need for a subsequent no-pay supplemental report. A robust dispute mechanism for "no-pay" reporting needs to be established. The currently proposed remedial report regulation will increase friction in the system not decrease it. The potential hassle of writing no-fee reports upon penalty of discipline will further diminish the QME pool not increase it.

6. The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report. Ideally, the cut off should be 7-14 days before the evaluation occurs. Rushed medical record review required by the present proposed regulations is extremely detrimental to injured workers who are then deprived of the evaluator properly reviewing the records.

7. Neurology and Internal Medicine evaluations should be entitled to a 2.0 X modifier.

8. To avoid the same QME fee problem in the future, the fee schedule should be subject to an automatic annual COLA increase.

9. Mental health modifier should be markedly increased.

Thank you for your consideration to my comments.

William W. Deardorff, Ph.D., ABPP, QME July 2, 2020

I complete very complex psych QMEs often requiring 60-100 page reports to address all issues. I will not do more than one QME per week due to the time required to address all issues. If the new fee schedule has no allowance for an hourly charge on these cases (e.g. ML-104), I would be forced to stop doing them. If a flat fee system is adopted, there still has to be an allowance for these types of cases. This would require the ability to bill for number of hours of work.

Ira Fishman MD July 2, 2020

1. Regulations poorly written.
2. Payment fix inadequate.
3. Changing working group recommendations after we made significant concessions is negotiating in bad faith.

Ira Fishman MD July 2, 2020

[Dr. Fishman in reply to Dr. Weinmann's comment below.] What I am seeing is the utter lack of skill from the DWC in crafting billing regulations. Each time so far the regs have been extreme poorly written, ambiguous and with many unintended consequences.

Neither attempt has provided fair reimbursement. In addition, the last attempt indicated lack of good faith in serious group negotiations with the DWC ignoring past negotiated agreements.

Unfortunately, the end result seems to be the indefinite postponement of our much needed and appropriate pay raise. Very discouraging.

Lynn Cintron MD July 2, 2020

President CALSIPP

I agree! **[Dr. Cintron is agreeing Dr. Weinmann's comment below.]** Thank you for recognizing the complex field of pain.

Robert L. Weinmann, MD, QME July 2, 2020

As for psychiatry reports, we should recognize that non-psyche QMEs are often asked neuropsyche questions, for instance, about **pain management**. These reports take as much time and effort as formal reports from psychologists and/or psychiatrists, e.g., review of medical files, disagreements among previous evaluators, and other **issues related to chronic pain.** The QMEs who do these reports deserve upgraded remuneration.

Mark Kimmel, Ph.D. July 2, 2020

I have been a QME for 35 years and was a member in stakeholder meetings hosted by the DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process. After in depth discussions and negotiations changes were made to favor the insurance carriers.

As the new DIR it is important to understand the DWC's demonstrated track record of bias towards insurance company interests and against injured workers and medical providers. This is part of a pattern of disturbing behavior on the part of Winslow West who attempted to purge over 500 QMEs for "underground regulations". I saw him speak at an Exam Works conference in 2018 where he told the QMEs that if they were unhappy then "just wait until I craft a new fee schedule". He actually said that and now he has done it. He either is unaccountable to senior management or has their support.

If this proposal is enacted there will be further attrition of QMES, exacerbating a crisis that the DWC audit documented. The insurance carriers at the workgroup meeting were quite clear they were willing to pay more for quality reports but that has not been a focus of the DWC. The audit recommends a 30% COLA.

Another egregious action taken by the DWC was the elimination of the neuropsychology specialty. As a neuropsychologist I am aware that many injured workers are being evaluated by psychologists without appropriate training and experience. I brought this to the attention of the DWC workgroup and there was unanimous support to reinstate the specialty. As far as I know no action has been taken to reinstate the neuropsychology specialty.

It appears that the DWC has particular enmity towards psychiatrists and psychologists that is unwarranted. In the DWC workgroup meetings insufficient time (approximately 20 minutes at the last meeting) was allocated to discuss psychiatric and neuropsychological evaluations and the resultant fee increase will only hasten the loss of mental health professionals.

I understand you are getting information from various sources and I hope you will listen to QMEs who have been on the front line evaluating and treating injured workers in a system that is deteriorating.

Emily B. Fine, Ph.D. July 1, 2020
Licensed Psychologist
Clinical Neuropsychologist
Qualified Medical Evaluator

The proposed QME fee schedule changes are unacceptable. It is shocking and disappointing that DWC is attempting, AGAIN, to reduce QME reimbursement, when we have not received a raise in 14 years!

The demand for QME evaluations has increased, while the number of QME doctors has decreased, but yet, the DWC has still not been willing to compensate doctors appropriately, which will likely continue to result in a decreased number of QMEs, unless there is a positive change in the fee schedule. I have continued to serve as a QME despite all of these issues, as I truly enjoy this type of work. However, as a psychologist, we would be adversely affected the most by the proposed fee schedule changes. It is essential that DWC understands the complexity of a QME psych evaluation and report writing and the significantly increased time required. If DWC comprehends this, you would know that the proposed fee schedule is truly unjust.

I urge you to replace this proposal with one where QMEs from **all** disciplines will receive an increase in reimbursement for all QME services provided.

Patrick J. Wymore, DC QME July 1, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the

stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

Sue Honor's proposal and the accompanying petition can be found here: https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

PS: I have been a QME since 1993, and it seems that in the last few years the DWC has been trying to incrementally take the QME system apart, to what end I don't know. If there is a long-term plan for the Workers' Comp system to jettison the QME system, we would all like to know about it so we can decide if we want to participate in that plan or not, and make our own plans accordingly. Otherwise, it would make sense for the DWC to make the QME system a viable part of the larger Workers' Comp system as a whole in order to attract and keep quality Dr.'s to be a part of that system by making it profitable to do so

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Oscar Rodriguez, DC QME July 1, 2020

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The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions and the opinions of those who participate in the QME system is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Carol Fetterman July 1, 2020

In spite of the DWC, et al. having received many emails and calls addressing the issue of the unfairness of the flat fee/reimbursement per page method of establishing fees for psyche evals, this has been completely ignored.

In light of this, I will attempt to explain in more detail why that method is unfair, by giving an example of a recent evaluation I have done. I have changed the facts somewhat in order to preserve anonymity, but have kept the relevant facts to illustrate my point. I am hoping that this detail will give you a sense of the complexity of most psychological evaluations.

The applicant in this case suffered a traumatic injury at work. On the face of it, it would appear it was 100% industrial causation, and if the proposed fee schedule were in effect, I would not have had the time to do the in depth interview that was required. It is likely that I would have found this to be 100% industrial. However, my clinical instincts told me the reported injury was excessive for the actual event. As a med-legal evaluator, I cannot use unsupported instincts to come to a reasonable medical probability. Therefore, a very extensive exploration and interview was required.

Let me also mention that the records in this case were less than 200 pages as is typical with psyche evals. We are lucky to get anything beyond cover letters. I did receive mental health records from the treating physician in this case, but there were no records that predated the date of injury, so I had no ability to find out about previous mental health history. Rarely are records inclusive of all health issues, and never have I received any personnel records or investigative reports. If the fee schedule is based on amount of records as is proposed, the fee for psychiatric evaluations will be reduced by more than 50%, let alone increased. Because of this dearth of records, the psychological interview and the testing must be much more extensive than for any other discipline.

The applicant in the above case was clearly anxious and depressed, but to such an extent, that he changed appointments, forgot appointments, and was unable to be interviewed or tested for more than two hours at a time. His first scheduled appointment was for the beginning of March, and the interview and testing was just completed yesterday, the 30th of June. (Some of the delay was due to the pandemic, but not all.) It was obvious that something extraordinary was occurring with this gentleman, but the treating physician was diagnosing him with PTSD only. I ruled out drug or alcohol abuse, delirium or dementia (due to his being an older gentleman.) There was only one other similar episode in his history which had occurred a few years earlier. He had a couple of meetings with a psychiatrist who diagnosed him with adjustment disorder. The applicant denied any other history of mental health problems or treatment.

The applicant's behavior was so erratic and severe that I suspected he had a pre-existing condition and that apportionment would be in order. I needed to substantiate this suspicion which required me to do a very thorough interview, but carefully, due to his anxiety. The result of this exploration, combined with the testing, suggested that this gentleman had a long standing Bipolar I condition, which had never been diagnosed or treated. This, of course, would result in different conclusions than had it not been discovered. Most importantly to note, was that I was able to come to a reasonable medical probability without the aid of records. Under the proposed fee schedule, I would not be adequately compensated for my time due to the lack of records and the inadequate modifier of the flat fee.

This case was unusual in the amount of time it took. I will not be able bill for all the hours spent on this case, but the compensation under the current fee structure is adequate. Most psychological cases are complex because psychology is not an objective science in the same sense as the other disciplines. The adjusters often do not comply with requests for records, for some reason, which would make the evaluation less difficult.

I hope this example of the complexity of psychiatric cases, illuminates the necessity for a separate fee structure for this discipline in order for the QMEs and AMEs to provide the quality of reports the injured workers deserve.

Marvin Zwerin July 1, 2020

I am a QME and CSIMS Member. I have learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

Unfortunately (but not surprisingly given DWC's demonstrated track record of bias towards insurance company interests and against injured workers and medical providers), DWC violated the stakeholder agreements in order to favor the insurance carriers.

Specifically, DWC made the following changes against the stakeholders' wishes:

	DWC Stakeholder Meetings	**California DWC Proposal**
Reimbursement per page	$3 (starting on page 201)	$3.00 (pages 201 – 2000) **$2.00 (pages 2001+)**
Definition of page	8 ½ x 11”	8 ½ x 11” OR **8 ½ x 14”**
Definition of re-evaluation	9 or 12 months	**24 months**

	DWC Stakeholder Meetings	**California DWC Proposal**
AME Modifier	1.25x and applies to **all services**	1.35x but applies **only to flat fee and not to depositions**
Medical records required to be sent 15 days prior to evaluation	Yes	**No**
Cover letter required to specify number of pages sent to doctor?	Yes	**No**
Automatic Annual COLA Increase?	DWC refused to hear this issue in the stakeholder meetings	**No**

DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.

- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.

- The mental health modifier should be increased to 3.0x

- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)

- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report

- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.

- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Cheri Adrian, Ph.D., QME July 1, 2020
Liscensed Psychologist

I am a psychologist who has served as a QME for DWC for almost 10 years, and I am writing to ask that you do *not* adopt the new fee schedule proposed by the DWC for psychological and psychiatric evaluations without major changes. This fee schedule will make it impossible to find competent psychologists and psychiatrists who can afford to serve as QMEs.

It is simply not possible to work the hours required for an adequate psychological evaluation for the payment the DWC is proposing. Psychological evaluations require an assessment of lifelong psychological issues, as well as an examination of every aspect of a person's life experiences at multiple time periods, to adequately assess issues of diagnosis, causation and apportionment. The proposed multiplier of 1.5 is at least half of what an adequate psychological evaluation would require. A modifier of 3.0 is barely adequate. And to have the multiplier not apply to records is baffling, since reading psychological records is an enormously complex task. Further, to have the payment for records decline as the records increase in number makes no sense at all, since more records means a more complex task of integration of information in those records. Finally, to pay as little as is proposed for a reevaluation also completely ignores the amount of work required to reassess an injured worker; after a year, the evaluation has to be virtually entirely redone.

It does not serve the interest of any worker, or any party to these cases, to pay so little that the evaluations will have to be radically cut back. We work very hard to provide complete and fair evaluations that can allow us to offer meaningful and adequate evidence for our conclusions about a worker's condition and status. This fee schedule completely undermines a worker's right to a full and well considered evaluation.

This fee schedule is unaccountably arbitrary; it does not honor the proposals agreed to after lengthy discussions between payors and QMEs. I do not understand how a DWC employee who has never served in these roles can arbitrarily make a decision about what fees are appropriate or workable.

The only part of this proposal that is near adequate is the proposal for fees for depositions. The discrepancy between these fees and those for the evaluations themselves makes no sense at all.

Please honor the stakeholder agreements that were reached, and add the following requirements which assure that QMEs will be given adequate time for and compensation for their work: I) Medical records should be required to be sent to the

QME *at least* 15 days prior to the evaluation. 2) Cover letters should be required to specify the number of pages sent to the QME. 3) A missed appointment should include appointments in which the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i). 4) The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation, not the date of issuance of the report. 5) A "remedial supplemental evaluation" should be called "an unreimbursed supplemental evaluation." The requesting party for such a report should be required to notify the QME of their intent not to reimburse them ***prior to performing the service***. The scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). There should be a dispute mechanism if QMEs disagree with the request in order to ensure that QMEs will have their due process rights preserved in any such dispute.

Please give careful attention to these issues.

Michael Fujinaka, M.D. July 1, 2020

My name is Michael and I'm an Anesthesiologist and Pain Medicine Physician. I practice in Northern California. I became a QME about 1.5 years ago and I recently went solo and am managing my own, solo, QME practice. There is a massive amount of paperwork and communications that go on behind the scenes to prepare and finish for a single evaluation. I would very much like to speak with you on the phone and share my perspective. I believe that you have heard a lot from large groups however, I can give you an opinion from a solo practitioner, managing my own practice, in the QME world. I can also give you feedback regarding why my colleagues, young pain doctors, don't want to be QME's (too high of a risk of getting legal action/ depositions and too little reimbursement, which I thought this Fee schedule might help address).

[Personal contact information has been redacted.] Please feel free to call or text me and I'd be happy to discuss the new fee schedule.

I found several issues with the new fee schedule.

While I appreciate that there is a cancellation fee, I believe the wording should include a phrase such as, "cancellations, rescheduling, or any failure to show up made within 14 business days will incur an xyz fee." The reason is, I take a full day off of work to do

QME evaluations. Thus, when I get a cancellation, even 6 days in advance is not enough to fill the slot, and I'm left twiddling my thumbs when I could have been working elsewhere. I believe there are legitimate reasons for cancelling a visit, but the doctor's time needs to be valued. The definition of a missed appointment is too narrow as it is. It should be expanded to include "for any reason the appointment does not take place is considered a cancellation".

I have noticed that insurances and adjusters find ways to make my job as a QME more difficult and stretch the rules. The language allowing "legal size," pages and the lack of language with regards to margins, line spacing, and font size are all ways that I can imaging insurances and adjusters taking advantage of me. Insurances and adjusters already use copy services to send me records and it would not be hard for them to ask the copy services to make the records into legal size 8.5 x 14" paper, reduce font size to 8, reduce margins to 0.25 inches all around, and reduce line spacing to single space. All these would still make the "page" count is 1 page but clearly, this is several pages condensed into one. I do appreciate that wording was put in so that multiple pages on 1 page will count as several pages.

I believe in the dwc's good intentions of removing the complexity modifiers which has been a headache for me as a solo practitioner in the QME world. In my opinion, the way that higher complexity cases would be reimbursed would be through higher page numbers. However, in the proposed schedule, I see that after a certain number of pages, whether it is 1800 pages, reimbursement actually FALLS to $2 per page. This is ridiculous to me because with more pages, comes more complexity. The rate should be the same no matter how many pages are sent reflecting the fact that more pages is likely higher complexity. If anything, then the price per page should INCREASE after a certain number of pages to $4 per page reviewed. With the flat fee schedule, there is no other way for Dr.'s time to be compensated for complexity except through medical records. This seems highly favorable to adjusters insurance companies when in fact, it should be up to them to pick and choose relevant records. Reducing payment for reviewing records to $2 per page seems to encourage adjusters and insurance companies to send irrelevant records. Please make all pages over 200 reimbursed at $3 for page; in order to reflect that with more pages comes higher complexity and this is the way to reimburse for the doctor's time.

In line with this, insurance companies and adjusters have taken issue with how I count pages; if they are sending records, they should be the one that count the number of pages sent to me. It is their responsibility to know what is being centimeters which includes a number of pages sent to me. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.

I take issue with the definition of a reevaluation being extended to 24 months. This is far out of the scope of practice. Even Medicare has designated that when the patient is

not seen for 12 months, after 12 months that is considered a brand-new patient. Imagine how much can change in 12 months time or 9 months time. A reevaluation, in my opinion, should be within 9 months of seeing the patient. Anything after 9 months, too much is changed to be considered a reevaluation and after 9 months should be considered a new patient. Again, this seems like a way to help insurance companies and adjusters who want to pay less for my time.

Though I have not been a QME for long, I believe there should be an annual COLA increase each year for QME reimbursement. Consider using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.

Insurers and adjusters have threatened not to pay me when they send me records AFTER I have written my report. When they send records to me LATE, they still expect me to include those late records into my report. Under the new fee schedule, this issue does not seem to have been fixed. The cut off date for arrival of medical records should be no later than the date of the face-to-face evaluation. This definition is easy to change and I hope it will be considered. (I would actually argue that medical records need to arrive 7 -14 business days before the medical legal evaluation. Then, I have time to review the records adequately. As it is, I spend hours and hours and my nights and weekends reviewing records. When the records are received far in advance, I can better conduct the evaluation to help the patients).

Lastly, I find it insulting to call the new supplemental type "remedial". Instead, this should be titled "unreimbursed". This is actually frightening to me and makes me consider leaving QME practice altogether. I can think of numerous ways that insurances and adjusters can abuse this. A simple way is that adjusters and insurance companies can begin writing 50 page cover letters with every question imaginable, and when I fail to address every question, the insurance company adjuster could simply order me and forced me to do an un-reimburse supplemental without payment. This is, frankly, unreasonable and far to open for abuse. I am not even clear that there is a way that DWC can protect me from frivolous requests for me to do free work through an un-reimbursed supplemental.

I appreciate that you are trying to give QME's a "raise", given that the fee schedule hasn't been increased for over a decade, but there are glaring problems that need to be addressed so QME's don't get taken advantage of.

Stuart Fischer, M.D., F.A.C.P., F.A.C.C. July 1, 2020

I am a QME and CSIMS Member. I have learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

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Cover letter required to specify number of pages sent to doctor?	Yes	**No**
Automatic Annual COLA Increase?	DWC refused to hear this issue in the	**No**

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- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Roger Nacouzi MD July 1, 2020

Comment on proposed medical-legal fee for internal or cardiovascular QME evaluation

The proposed flat fee for initial QME exam, follow up exam or supplemental report may work for a simple injury involving a single body part, but does not come remotely close to cover basic cost of a 200 page internal or cardiovascular comprehensive evaluation because most of the time there is a need to analyze in detail controversial physical and emotional factors involving multiple body parts, review multiple orthopedic and psychiatric evaluations, consider toxic/infectious/carcinogenic factors, search medical

literature, review depositions and statements in addition to medical records that can all be packaged in a file close to 200 pages.

- The fee for each evaluation should be more than doubled from the current (20 y/o) relative value of $ 12.5 per unit of time to $ 30 per unit of time
- Keep all the current ML codes, including ML 104. The complexity of the evaluation is the major factor determining the appropriate level of service.
- No show / Late cancellation fee $ 800 to discourage misuse of QME time

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Suresh Mahawar, M.D., FAAPMR, QME, IME July 1, 2020

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- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)
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- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.
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Clinical/Forensic Psychologist

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- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Joshua Kirz, PhD July 1, 2020

I know many individuals at the DWC and have always been impressed by their dedication. I truly believe those at the Division want to “do the right thing,” namely helping injured workers and keeping the workers compensation system functioning smoothly. That is why I have been so mystified over the past two years by the MLFS proposals.

To quote the great Charles Oakley, “If it ain’t broken, don’t break it.” Why the DWC has chosen to break the old fee schedule remains beyond me. There is an Audit Unit out there for those that abuse the system.

Further, complexity factors just simply “make sense.” Complexity = Time. Pages of records are not a proxy for time. The only proxy for time is . . . time.

Any flat rate system will only incentivize doctors to spend the least amount of time with the injured worker and the least amount of time on the report. It will be a race to the bottom. Quantity over quality. The good doctors will leave the system. Injured workers will be harmed. Cases won’t settle. Friction won’t decrease – it will increase.

And yet this is where we are. Insurance profits are not down – they’re up. Med-legal expenses are not up – they are exactly unchanged since 2013 (6% of costs). Panel QME requests are not down – they’re up. Doctors willing to serve as QMEs are not up – they’re down. And finally, there has not been a cost of living increase (or any increase) since 2006.

Needless to say, the MLFS needed updating, such as the bumps for ML102s, ML103s, depositions, and the fee for no-shows. These improvements are dramatically overdue, but quite welcome. They may help attract orthopedic specialists, which I know is a major concern for the Division.

Unfortunately, any good done with the changes above will be undone (and then some!) by the cuts to ML104s and supplemental reports.

Even more unfortunate for me as a psychologist, most of my evaluations are 104s. We are not like orthopedics, where there is a mix of high, medium, and low complexity cases.

In psych, we *used* to have low complexity cases – they were called compensable consequence claims and they were nixed by the state legislature in 2013. (Some of those cases could be complex, too, but most were pretty straightforward and could be completed in 10 hours, give or take.)

All that’s left are the complex cases, such as complex polytrauma, workplace harassment, personnel action claims, etc. They’re practically all 15-20 hours now. I can only see 2-3 cases per week, perhaps ¼ as many as my physical medicine colleagues. That’s why you’ll get lots of complaints about this proposal from psych docs.

(Again, it’s not the psych doctors taking excessive time – it’s the combination of psych being inherently complex and the state legislating out the few low-complexity psych claims.)

If the DWC insists on a Nevada-style flat rate system, why pay less than Nevada (in overall reimbursement), despite the much higher cost of living in CA? Why dismiss Sue Honor’s proposal out of hand? Why renege on multiple issues that were agreed to by the payor community during the stakeholder meetings?

The only ways I can imagine the current proposal even coming out even (*even*, not an increase) with the current system would be:

1. Give psych a 3x modifier (and find a way to give a similar modifier to unusually complex physical cases – not sure how to do that - I'm not a specialist in that area)

2. Remove all the likely gamesmanship likely to come on records (eg, $3.25/page for ALL pages, 8.5x11 only, double spaced only, etc.).

3. AME modifier to all AME charges, as it is now.

4. Get rid of that silly "remedial" supplemental – that is just begging the carriers to abuse doctors.

All of the above is simply to break even on the new schedule. Anything less and I'd have to consider leaving the system. All the good, "in demand" doctors will likely do the same.

For an actual increase, since there hasn't been one in 13 years, pay QMEs an hourly rate of $325 as recommended in the audit and institute a COLA, like many other groups have in the DIR.

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Joan Palmeiri
Benedict Billing Solutions, Inc.

July 1, 2020

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- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Teo Ernst, Psy.D., ABPP, QME July 1, 2020

I am deeply concerned with this schedule If enacted, this fee schedule will increase the administrative burden on QMEs, not compensate them fairly, and undoubtedly reduce the already record-low number of QMEs still left in the system.

As a psychologist, the base rate of $3000 on new evaluations, and $2000 on re-evals, is simply untenable, in a California economy, given the necessary administrative costs to schedule/bill QME's and the time required to complete a high-quality report. I urge DWC to increase the multiplier to at least 2.0x **and** apply the psych multiplier to record review fees, not just the flat fee.

Although I sincerely wish to function as a QME and am committed to the service QME's provide, I fear that this will be the final straw, for myself as well as the QME's who have stayed in the system despite 14 years without a pay increase.

I respectfully request that you strongly reconsider this fee schedule.

Debbie Ortega, Business Manager July 1, 2020
Adelberg Associates Medical Group

Please find my written response to the proposed QME fee schedule posted to the DWC website for comment. It is a disappointment that the agreements made during the Stakeholders meeting were not honored by the DWC and rather, reductions made that greatly affect the QME and will reduce Doctors interest in becoming a QME.

The proposed rates, lack of COLA, requirements for QME's to work for free and to take on additional burden's without compensation all become a deterrent for anyone to continue in the system or to be able to provide much needed evaluations to the Injured Worker's. This system is already lacking in the number of QME's needed, this will surely cause more deterioration to the system and continue to harm the Injured Worker's access to evaluations.

Having reviewed the 6.25.20 proposed changes to the OMLFS there are several areas that are unacceptable. This latest proposal is NOT in fact an increase overall; first, re-evaluations should be within ONE YEAR and only for the same injury. The Psychologic rate should be increased at a rate of 3x the proposed rate of $2015, anything short of that will be a cut in reimbursement. Additionally, the specialties of Internal Medicine, Pain Management (PM&R) and Neurology should also be at a higher rate. This proposal again shortcuts reimbursement to the QME, does not accommodate for complex cases of multiple injuries, body parts or apportionment issues. It burdens the QME and staff to manage the records process and perform tasks without compensation, all to benefit the insurance companies.

Sue Honor's fee proposal and the Stakeholder agreed proposal supported the QME efforts and fairly reimbursed QME's for the work performed. The current proposal shifts much of the burden to the QME and expects work to be done without any requirements for the Insurance or Attorney's to provide complete records in advance, outline disputes, or clearly ask specific questions. Records should be required to be provided weeks in advance, organized and in order. If not received in advance, there should be additional compensation and time provided to the QME for their production of the report. The requirement for the QME to provide free supplemental reports **for any issues**, or topics the parties *feel in their interpretation* are not satisfactorily addressed at no charge is completely unacceptable.

The insurance has manpower and resources to handle the records management and to supply the QME only those records that need to be addressed in an organized manner and provided legibly without duplication, **IN ADVANCE**. Fee's for QME review should include **up to 50 pages** of records at a page length of **only [8.5 x 11]** with all additional paid at the flat rate of $3.00 per page. There should not be a differing rate per volume of records or a variance in page length.

All supplemental reports requested by any party or to address any subsequent issue should be paid at the supplemental report rate; including 50 pages of records with any additional records paid at the per page rate of $3.00 per page. Working for free will not promote new QME's into the system nor will it encourage current QME's to remain.

There is no COLA included in this proposal as has been done for other fee schedules recently proposed by the DWC. It is shameful that the DWC has been allowed to go 13+ years since adjusting the fee schedule for QME's. This would encourage more Doctors to become QME's if they knew that this would be fairly reviewed and increased annually.

The proposal to require the QME to provide services for free any time another party interprets a report as needing a "remedial" supplemental report is unacceptable and clearly biased against the QME's. This will cause conflict between the QME and the Insurance and add to even greater disputes in interpretation of what is reasonable. **Attorney's and Adjusters get paid for the work they do and in fact get paid whether they provide the information in a timely manner to the QME or not… QME's should be treated in the same manner.**

Roy Curry M.D. July 1, 2020

Respectfully request considering Sue Honor's proposal. It seems more equitable to QMEs. Also request considering applying the psych modifier to the record review and allowing the first 300 pages to be paid at a higher rate not 200. Often there is a

deposition of 100 pages which involves more time comparing this information with the patient's history and the other records to determine if there are consistencies.

Gregory L. Marusak M.D. July 1, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In a system with too few doctors, many quality physicians have avoided becoming a QME or recently left because they can make much more in other avenues of medicine without the hassle of dealing with the DWC. Despite the ongoing refusal to increase pay since 2006, the laughable slow response to COVID and the underground regulations debacle, I have continued to serve as a QME but, this proposal will be the final straw for many providers, including myself. You will lose more physicians, fail to attract new physicians and delay the process for injured workers.

In December 2018, the DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

Sue Honor's proposal and the accompanying petition can be found here: https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

The fact that you have disregarded essentially all of these qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Steve Dell, MD July 1, 2020

I am surprised at and very disappointed in the proposed revisions to the DWC fee schedule: the first in 13 years!

Subject: DWC Did Not Honor the QME Fee Schedule Stakeholder Process

I am a QME (spine, neurosurgery and neurology), and CSIMS Member. I have learned that CSIMS and other provider groups met with DWC and payor groups over the past several months in stakeholder meetings hosted by DWC. The outcome of the stakeholder meetings was a mutual agreement between payors and providers on several key terms. I am disappointed to learn that DWC did not honor the terms that were agreed upon in the QME stakeholder process.

Unfortunately (but not surprisingly given DWC's demonstrated track record of bias towards insurance company interests and against injured workers and medical providers), DWC violated the stakeholder agreements in order to favor the insurance carriers.

Specifically, DWC made the following changes against the stakeholders' wishes:

	DWC Stakeholder Meetings	**California DWC Proposal**
Reimbursement per page	$3 (starting on page 201)	$3.00 (pages 201 – 2000) **$2.00 (pages 2001+)**
Definition of page	8 ½ x 11”	8 ½ x 11” OR **8 ½ x 14”**
Definition of re-evaluation	9 or 12 months	**24 months**
AME Modifier	1.25x and applies to **all services**	1.35x but applies **only to flat fee and not to depositions**
Medical records required to be sent 15 days prior to evaluation	Yes	**No**

	DWC Stakeholder Meetings	California DWC Proposal
Cover letter required to specify number of pages sent to doctor?	Yes	**No**
Automatic Annual COLA Increase?	DWC refused to hear this issue in the stakeholder meetings	**No**

DWC should modify the fee schedule in the following specific ways:

- All pages over 200 should be reimbursed at $3/page
- Pages should not be legal sized, only standard sized
- A re-evaluation should be within 9 or 12 months of the last med-legal exam, not 24 months
- The AME modifier should be 1.25x and apply to all services including the per page fee
- Medical records should be required to be sent to the QME at least 15 days prior to the evaluation
- Cover letters should be required to specify the number of pages sent to the QME. The party sending the records should include a declaration under penalty of perjury attesting to the number of pages.
- The fee schedule should include an automatic annual COLA increase for QMEs. I recommend using DWC's State Average Weekly Wage inflationary metric or, alternatively, the CPI For Medical Care in California.
- The mental health modifier should be increased to 3.0x
- The definition of a missed appointment is too narrow and should be expanded to allow for: the injured worker leaves prior to completing the evaluation, the interpreter does not show up for the evaluation, the interpreter leaves prior to

completing the evaluation, the evaluation is discontinued by QME due to rudeness or abusive behavior by injured worker under 41(h), the evaluation is discontinued by QME because injured worker is intoxicated or otherwise medically unable to complete the evaluation under 41(i)

- The cut-off date for QMEs to include records or a sub rosa in a face-to-face evaluation report rather than in a supplemental evaluation should be the date of the evaluation not the date of issuance of the report

- The way in which an unreimbursed "remedial supplemental evaluation" is defined is unacceptable and unfair to QMEs. DWC should rename this to "unreimbursed supplemental evaluation" to clarify the intent of this "service." Second, the requesting party for such a report should be required to notify the QME of their intent not to reimburse them for writing a supplemental evaluation and should be required to title any such request, "Request for Unreimbursed Supplemental Evaluation" so that the QME is aware of this ***prior to performing the service***. Third, the scope of what would qualify for such an evaluation should be narrowed to only include circumstances in which the QME allegedly violated 10682(b). Fourth, there should be a dispute mechanism if QMEs disagree with the request and believe they should be reimbursed for the supplemental evaluation. DWC should create a separate dispute resolution protocol with its own regulatory schema in order to ensure that QMEs will have their due process rights preserved in any such dispute. DWC should hear and make timely determinations on such disputes and be required to publicly post the outcomes of such disputes so that the public can see how often the DWC rules in favor of payors or QMEs.

- Oncology and Toxicology modifiers should be allowed to be used for any QME who performs an evaluation where oncology or toxicology is the primary focus of the evaluation. It should not be restricted only to QMEs board certified in these specialties.

- Neurology and Internal Medicine evaluations should be entitled to a 2.0x modifier.

Further, I am surprised that there appears to be no written record of the Stakeholder meetings and their agreements. And this from a roomful of lawyers! It is incumbent that you produce those records and justify the changes from them that the DWC proposes.

Douglas Drucker, Ph.D. QME July 1, 2020

I am a psychologist QME. I have been providing reports as a QME and AME for eight years now. The proposal you have made would significantly affect my practice negatively. I primarily write ML 104 reports. The Psychology report is quite different than other med legal reports, it requires much more time with the applicant, preparing the report, reviewing data, etc. Simply put, it is a much more complex report. The proposed fee schedule would require that I either spend much less time on reports, or be paid much less for similar work, or the third more likely option for me, is that I would discontinue doing these reports. It is my understanding that the proposal initially made with stakeholders, the QMEs was a much different plan. The plan you chosen\ to present fits with what the insurance companies requested, as a cost saving measure, which serves their interests. The current proposal would save money. It would also very likely create a crisis, where many QMEs would drop out of practice, such a myself. This would in turn generate a large gap of need for new QMEs, which would be extremely difficult to fill, given the pay structure. I request a change in the plan for psychiatric QMEs. Your plan represents a large pay cut for us. Given the fact that there has not been a pay increase in 16 years, this is insulting to us. I do understand that you are attempting to ensure quality reports that are cost effective. Some of us write excellent reports, I do. Simply slashing expenses will not deliver the goal, in my opinion.

Jeffrey M. Stern, Esq. June 30, 2020

As an Applicant Attorney, I have firsthand experience dealing with many of the issues surrounding the PQME system. Many cases require quality reporting from a Panel QME. In recent years, many physicians have left or were kicked out because of alleged regulator violations. Unfortunately, the quality of the average report has fallen and in numerous specialties, there are an insufficient number of physicians to even issue a panel. By not paying the physicians a reasonable fee, I fear that more physicians will leave the system and few will be willing to enter the system. With fewer physicians in total, the injured worker will suffer.

Please reconsider the Med-Legal Fee Schedule and consider adopting the proposal drafted by Sue Honor that had the support of the QME community.

Leonard Gordon MD, AME June 30, 2020

I need to comment on my previous email. We must have a new fee schedule without further unnecessary delays. I implore the DWC to listen to those doing this work so a reasonable compromise can be reached to move forward. The unreasonable aspects should be removed.

Some of these are the definition of a re-evaluation which should be 9 months at maximum, the varied reimbursement for record review amongst other aspects.

David Narang, Ph.D June 30, 2020

I write out of significant concern about the DWC's proposed changes to the Medical-Legal Fee Schedule. I would not be able to remain a QME if this is enacted, and I have already spoken with others who are of the same mind.

If enacted, this fee schedule will increase the administrative burden on QMEs, not compensate them fairly, and undoubtedly reduce the already record-low number of QMEs still left in the system.

DWC has intentionally NOT applied the psych multiplier to record review. This makes no sense. Reviewing medical records from a mental health perspective is inherently more time-consuming and complex than reviewing medical records for a non-psych specialist.I urge DWC to increase the multiplier to at least 2.0x **and** apply the psych multiplier to record review fees, not just the flat fee.

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders. Why has DWC ignored this widely supported proposal?

Sue Honor's proposal and the accompanying petition can be found here:https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

Further, the fact that DWC has disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement DWC proposes is far below Sue Honor's recommendation and even less than the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, unfortunately including myself.

I urge DWC to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Christopher T. Simonet, Ph.D. June 30, 2020

The proposed changes are unacceptable. If enacted, this fee schedule will increase the administrative burden on QMEs, not compensate them fairly, and undoubtedly reduce the already record-low number of QMEs still left in the system.

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I urge DWC to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Leonard Gordon MD June 30, 2020
AME State of California

Thank you for the work on revising the med-legal fee schedule. An update of this schedule is way overdue.

While there are still problems that remain, I believe this to be a good first step in the process.

Considering the inordinate delays that we have seen, I strongly support moving forward expeditiously with this new schedule.

Joan Palmeiri June 30, 2020
Benedict Billing Solutions, Inc.

It was my understanding that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. I also understood that progress was made for fair and equitable changes for ALL QME specialists were discussed and terms were agreed upon. As such, I am again truly disappointed that DWC has undercut these levels and is attempting to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings. How is it that we are paid less than QME's in Nevada given our California cost of living is significantly higher? This is profoundly disappointing and this latest proposal is unacceptable.

Moreover, in December 2018, Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is truly demoralizing and disheartening.

Many of my colleagues will have to determine whether they will continue serving as a QME. Some have already left by their own choice and more will abandon their role now. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Christina Averill, Ph.D., QME June 30, 2020

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I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported

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Mark Kimmel, Ph.D. June 30, 2020

The proposed fee schedule will result in less comprehensive evaluations that will be a disservice to injured workers. Psychologists and psychiatrists have a more complicated task in performing their evaluations and a 50% increase will not provide enough time to conduct such an evaluation. Many reports will not constitute substantial medical information and those that do will provide the bare minimum prompting requests for

supplemental reports and depositions. These inefficiencies will cause delays workers receiving treatment and in settling cases. The unintended consequences are also likely to be more costly than a more generous fee increase. The adage, “you get what you pay for” is appropriate in this instance and the complaints of poor quality evaluations will likely increase. As a member of the DWC work group I heard various perspectives on the fee schedule and heard that payers were willing to increase fees if they were assured of quality evaluations.

A 100% increase for psychologists and psychiatrists would be minimal to the overall system but would incentivize evaluators to provide better quality reports. I also would recommend that an effort should be made to educate QMEs and establish standards for QME evaluations

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Dr. Michael D. Zeger, D.C., Q.M.E. June 30, 2020

The new proposed Med-Legal Fee Schedule has two major flaws.

First the proposal that the qualified medical examiners should only be paid to review medical records after the first two hundred pages is the same as asking the QME to work for free. Insurance companies demand that their premiums be paid, or you lose your insurance coverage. Attorneys expect to be paid for their part of the workers compensation process or they take you to court. Judges certainly expect to be compensated for their work. Court reporters and interpreters expect to be paid, even for missed appointments! So how is it reasonable for the med-legal fee schedule to allow for a loop-hole that will cost the qualified medical examiner hours of extra time and yet not compensate them. It is simply unreasonable. If there are any medical records to review, the qualified medical examiner should be compensated for reviewing those records.

Secondly, for years, the insurance company has refused to pay missed appointment fees based on an equivocal line in the current med-legal fee schedule which states, "ML100: Missed appointment for a Comprehensive or Follow-up Medical-Legal Evaluation. This code is designed for communication purposes only. it does not imply that compensation is necessarily owed." Just this month I have had four cancellations of medical-legal exams, some of which were on the night before the exam was about to take place. This means I cleared a minimum of a half day of patients in order to perform an exam and I won't be paid a dime for that time lost. There is no way I will have time to adjust my schedule in circumstances like this. Unfortunately, this practice is not an isolated incident. Attorneys and insurance companies have no regard for the time of the medical examiners and have no ramifications for wasting our time. It was a large

enough problem that the proposed med-legal fee schedule actually addresses and fixes this problem, which I am happy about.

However, the proposed med-legal fee schedule now has a similar clause that allows insurance companies and attorneys to decide whether or not a supplemental report is compensable. This is simply absurd. Why would the insurance company ever pay a supplemental fee, when they can just state that the supplemental should have been covered in the original report? it doesn't matter if that is true or not, the insurance company's opinion is the only opinion that matters. Supplemental reports are not easy and usually require a re-review of records and a review of reports in order to satisfy the questions being asked. The proposed med-legal fees schedule is simply asking the medical evaluators to perform supplementals for free. Attorneys will simply request supplemental after, after supplemental, after supplemental until the evaluator gives them the answer that they want to hear. I know, because that happens now.

Placing loop-holes in the proposed med-legal fee schedule, as I have described above, is going to cost the whole system time and money. Every time I have to have my staff contact a claims adjuster to collect on an unpaid med-legal fee, it costs me money and time and the insurance company money and time. Leaving vague and equivocal statements in the med-legal fee schedule is going to cost millions of dollars in time, money, and litigation. It will cause an already slow system to bog down even further.

Alison Magoun Moreno, Ph.D., QME June 30, 2020

I am a clinical psychologist who has been a QME for the past few years. I find the proposed changes to be unacceptable. If enacted, this fee schedule will increase the administrative burden on QMEs, not compensate them fairly, and undoubtedly reduce the already record-low number of QMEs still left in the system.

DWC has intentionally NOT applied the psych multiplier to record review. This makes no sense. Reviewing medical records from a mental health perspective is inherently more time-consuming and complex than reviewing medical records for a non-psych specialist. Furthermore, I have found that often valuable information is obtained from a careful and thorough review of such records. I urge DWC to increase the multiplier to at least 2.0x **and** apply the psych multiplier to record review fees, not just the flat fee.

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also

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Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Many qualified physicians have avoided becoming a QMEs because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge DWC to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

John M. Warrington, Ph.D., QME June 30, 2020

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I urge DWC to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Arbi Mirzaians DC June 29, 2020

Specifically, I am referring to the following language of the code descriptor for ML 206:

ML206
($0) Remedial Supplemental Medical-Legal Evaluations. This code is designed for communication purposes only. It indicates and acknowledges that compensation is not owed for this report. This code shall be used for supplemental reports following the physician's review of: (1) information which was available in the physician's office for review or was included in the document record provided to the physician prior to preparing a comprehensive medical-legal report or a follow-up medical-legal report, (2) addressing an issue that was requested by a party to the action to be addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation, or (3) addressing an issue that should have been addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation pursuant to the requirements for a medical-legal evaluation and or report as required by any provision of title eight, California Code of Regulations, sections 9793, 9794 and 9795. Fees for supplemental medical-legal evaluations. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the

physician. Fees will not be allowed under this section for supplemental reports following the physician's review of (A) information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing the initial report or (B) the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation.

An additional concern which requires clarification within the MLFS is that of duplicate records. There are instances when the additional records submitted to the QME to review, contain duplicates of medical records previously submitted to the QME for review.

First, it requires that the QME review these records in order to discover which, if any, of the records are duplicates.

Second, as it applies to medical record review, it would only be reasonable to expect that the QME would be reimbursed at the per page reimbursement rate at any time additional records are submitted to the QME for review regardless of whether or not duplicate records are included within the records provided for review.

It is asked that the requirement to reimburse the QME for review of any duplicate documents clearly be outlined within the MLFS.

It is simply not feasible to not only review duplicate records without reimbursement, but to go through the arduous process of attempting to identify which of the records are in fact duplicates.

I respectfully ask that you review, consider and address these matters in the final version of the MLFS.

Michelle Furuta MD, QME June 29, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500

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This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

J. Stuart Meisner Ph.D. June 29, 2020
Clinical Psychologist

The proposed changes are unacceptable. Quality psychological evaluations cannot be performed in most cases for this reimbursement rate. This opinion is based upon my 35 years experience providing these evaluations. During this period, I have trained other examiners and reviewed a huge number of examinations. There is a lot of low quality work out there. Those who remain under the proposed schedule will do a disservice to the entire endeavor. I will discontinue being a QME if it is accepted.

I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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William W. Deardorff, Ph.D., ABPP, QME June 29, 2020

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Michael A. Sommer MD June 29, 2020

It does not seem logical to exempt record review from the AME upcharge. After all it's usually what's in those records (gaining a good understanding of them) that makes such a case so difficult that it's an AME in the first place!!

Andrew (Andrzej) Bulczynski, MD June 29, 2020

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Mohammad Hanizavareh June 29, 2020

I have read the newly proposed changes to the DWC med-legal fee schedule and I have found them to be largely inadequate. I understand the purpose of the proposal is to reduce complexity and costs for insurers but I believe they are largely unworkable as written. The new schedule essentially proposes that psychiatrists perform the entirety of a med-legal evaluation and report within 12 hours if they do not want to take a pay cut. That includes a forensic psychiatric interview, psychiatric testing, record review of 200 pages and in-depth analysis. A quality evaluation and report cannot be completed in this time. Period.

Let's clarify what each aspect of a psychiatric evaluation requires. A forensic psychiatric interview, which a qualified/agreed medical evaluation is, requires multiple parts. There are directed questions towards obtaining basic aspects of history. There is an open-ended interview to obtain the history of industrial injury as well as nonindustrial factors. There is also the requirement of verifying/checking the history vs what is obtained in the record. Each aspect takes a significant amount of time. I generally average well over 4 hours per interview and have gone as long as over 7 hours. I do not see a thorough interview lasting less than 3 hours. A lengthy interview is required for a number of reasons, the first of which is that applicants seen in this system often have very little insight into the exact nature of their injury. For example, a very common situation is an applicant claiming emotional distress arising from a physical injury, multiple personnel actions and work stress. It takes time to parse this out with the applicant and arrive at what he/she believes is the predominant cause of the injury. Second, obtaining a thorough nonindustrial history requires a lengthy, open-ended interview in which the applicant is allowed to speak at length about his/her life. Just a few weeks ago, I had an applicant who responded "I don't know" when initially asked if they had ever experienced any form of abuse. When I rephrased my question and explained what I meant by abuse, the applicant denied experiencing the abuse. However, she appeared upset at the question so I asked the applicant a third time at a much later point in the

interview. The applicant broke down crying at this point and acknowledged being seriously abused. This whole process took over an hour, just to obtain a single factor of apportionment and this is a common occurrence during evaluations. Third, a psychiatric interview must consider credibility and motivation. This requires fact-checking/verifying with the records, sometimes line by line.

All of these portions of the interview require time and are absolutely critical aspects of a thorough psychiatric evaluation. Given the lack of time supported in the new billing proposal, I strongly believe that those who have been performing their evaluations in this manner, will no longer spend the time to get these additional details. Without these factors, I strongly suspect that most psychiatric claims moving forward will be found predominantly industrial as the applicant initially describes them, without analysis of different possibilities for causation (ie work stress vs ortho injury vs personnel action) and will not include a detailed apportionment analysis. Given the disincentive to perform re-evaluations, I also suspect that more applicants will be found P&S after their first evaluation. This will mean that insurers will actually see more predominantly-industrial claims, with lower GAFs and less in the way of apportionment.

Let's say that psychiatrists continue to perform thorough interviews in the context of the new billing regulations. Given that I have averaged over 4 hours per interview, let's round down to 4 and that leaves me with 8 hours to review 200 pages of records and write my report. Assuming I review those 200 pages in 2 hours, though I would argue that psychiatric treatment records and a deposition with a psychiatric focus take much longer to review, I am left with 6 hours to write my report. This is again if I do not want to take a pay cut. My current reports average around 70 pages and I have had two in the past few months that were over 150 pages in length. My reports do not contain the repetition seen in many treating provider's reports and I spend time discussing my analysis of every factor in my reports and include a thorough explanation of my reasoning for each opinion. It takes longer than 6 hours to do this in every single case.

For example, my most complex case this year involved a person with a claimed psychiatric injury stemming from a specific injury accident. This person was claiming a traumatic brain injury with ongoing symptoms years after the injury, posttraumatic stress disorder and major depressive disorder. The applicant had seen many, many doctors (none were psychiatrists) since the accident and they had prescribed many, many psychiatric medications and offered the diagnoses above without any analysis or explanation. The applicant also had a history of another prior industrial injury some 20 years prior with no interval work history during that time, a lengthy history of nonindustrial major depressive disorder, heavy substance abuse, lengthy prison time, the death of a child and a number of other major nonindustrial factors. There is simply no way to parse any of this out AND explain this to the parties in the allotted time of 6 hours. This may seem an uncommon scenario but even other cases in which I have a relatively young applicant who is claiming only a clear specific injury stemming from a

one-time accident require more thorough analysis than 6 hours provides. If doctors aren't paid for their analysis, they will not provide it. I understand the newly proposed regulations provide a code for remedial evaluations in which we will not be paid in order to answer questions someone arbitrarily decides we should have in a previous report, but I do not believe any doctor will operate in a situation in which we are expected to work for free.

To be clear, psychiatrist rates these days around $300/hour for contract/public clinical work and more for private clinical work. Forensic expertise is also generally paid at an even higher rate. The new regulations expect us to perform our work in 12 hours if we want to continue receiving the $250/hour we currently receive under ML-104. If we spend over 12 hours completing an evaluation, from interview to sending out a completed report, we will receive a substantial cut in our current pay. I do not believe 12 hours is adequate for all of the factors that go into a thorough psychiatric evaluation. I do not believe the parties can expect a thorough evaluation and report under the newly proposed guidelines. I also do not expect any doctor would be willing to work for free as expected to under ML-206. I am also unclear if the new proposal will meet its purpose of saving insurers money as more applicants will be found P&S at the first interview (usually with a lower GAF than they would have otherwise with recommended treatment), more claims will be found industrial at face value (ie without analysis of credibility/motivation or whether work stress vs personnel actions vs ortho etc were primary) and there will be less in-depth analysis of the factors of apportionment.

One could posit that we, as empathic and altruistic medical professionals, should be willing to take a pay cut in order to deliver high quality care to the applicants we see. However, one could also say that our skills would better serve applicants and patients in general if we simply stopped performing these types of evaluations and simply focus on direct patient care. QMEs/AMEs are varied in their motivation to continue performing this type of work, but at some point the math of time vs money turns factors in and the DWC will lose doctors that are willing to do a good job. Given these repetitive proposals of late, it appears that the DWC will enact some approximation of this fee schedule soon. I hope that you have considered the ramifications to the applicants, insurers, the system and yourselves

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William Tappin, Esq. June 29, 2020
Tappin and Associates

I will leave the discussion of the various modifiers relating to different medical specialties to the doctors impacted by those modifiers. However, with respect to modifier No. 93, it seems inadequate to address the time involved. Each question from the doctor has to be translated into another language. At that time, the patient

responds in another language. The patient's response is translated back into English. In addition, many patients repeat the question, which generates even more questions. I think the time involved when there's an interpreter increases the period of the examination by one-third or more. However, I do think the modifier should move from .1 to .2.

Additionally, because many of the carriers, administrators, and employers ask and often won't accept the basis for the increase in time relating to interpreters. The regulation should indicate the language the doctors need to use to guarantee they receive that modifier, whether it's .1 or .2.

William Tappin, Esq. June 29, 2020
Tappin and Associates

Doctors are subject to scrutiny and potential discipline for refusing a Panel Qualified Medical Evaluation assignment. The issue of the Uninsured Employer's Benefit Trust Fund must be addressed in the proposed medical-legal fee schedule regulations. I think most doctors who will issue comments with respect to this would agree that it is difficult, if not impossible, to be paid on a timely basis by the Uninsured Employer's Benefit Trust Fund. Regulations should be drafted requiring the Uninsured Employer's Benefit Trust Fund to be subject to the provisions of Labor Code § 4622 to further support the legislative intent that medical-legal providers be paid properly and timely. At the present time, doctors either are not paid at all or are paid four or five.years later.

That's inappropriate.

One has to question why an illegally insured employer gets a greater consideration than the medical-legal provider. In order to obtain a medical-legal report in an insured employer case, a fund should be established or some provision made for the doctor being paid within 60 days, as with other cases. Alternatively, a doctor should, at his sole discretion, be able to refuse to accept uninsured employer cases without a guarantee of payment enforceable at the Workers' Compensation Appeals Board. If an attorney sends a case to a doctor as an Agreed Medical Examiner or panel Qualified Medical Examiner without advising that the employer is uninsured, the attorney should be required to post payment or have his client post payment of a fixed amount in advance of the evaluation. In addition, the attorney must advise the medical legal provider that the employer is uninsured. If some provision is not made for payment on a timely basis on an uninsured employer cases, doctors should have every right to refuse to do an evaluation. If there is a provision regarding required payment

by the Uninsured Employer's Benefit Trust Fund, I am unaware of it. Does the Uninsured Employer's Benefit Trust Fund fall under the provisions of Labor Code § 4622 and the administrative regulations?

William Tappin, Esq. June 29, 2020
Tappin and Associates

Medical legal providers should be given the option to refuse Panel Qualified Medical Evaluations in cases where they have had ongoing issues with the carrier, administrator, or employer regarding payment of their invoices. It seems that a doctor should not be required to continue a relationship with a carrier that continually fails to pay either timely or appropriately.

Does Title 8 California Code of Regulations Section 41.5(d) govern this issue. Section (4) states:

"Any other relationship or interests not addressed by subdivision (d)(1) - (d)(3) which would cause a person aware of the facts to reasonably entertain a doubt that the evaluator would be able to act with integrity and impartiality."

Additionally, Title 8 California Code of Regulations Section 41.5(e) states:

"An Agreed Medical Evaluator or a Qualified Medical Examiner may disqualify himself or herself on the basis of conflict of interest pursuant to this section whenever the evaluator has a relationship with a person or entity in a specific case, including doctor patient, familial, financial or professional, that causes the evaluator to decide it would be unethical to perform a Comprehensive Medical-Legal Evaluation, examination or to write a report in the case."

If a medical legal provider has a relationship with a carrier, administrator or employer which is negative and, which the doctor feels would impair his or her ability to issue an unbiased report, would they be able to refuse the assignment? If so, what procedure would they follow. Should this be clarified in detail in the Regulations. The above referenced section does not say the relationship has to be positive, it merely says a relationship, which could in fact be negative.

I also note Title 8 California Code of Regulations Section 41.6(d) which states:

"Any dispute on whether a conflict of interest of an evaluator may affect the integrity and impartiality of the evaluator, with respect to an evaluation report or a supplement report, and any dispute over a waiver of an evaluator's conflict under this section shall be

determined by a Workers' Compensation administrative law judge."

41.6 relates to procedures after Notice of a Conflict of Interest and waivers. The Code infers this would be exercised by one of the parties and perhaps not the doctor. However, if a doctor reporting as a medical legal provider has an ongoing issue with any particular insurance company, administrator or employer that the doctor feels would cause them concerns about their ability to issue an unbiased report, shouldn't they be able to refuse the assignment without penalty?

I think this should be addressed. I know it's someone outside the fee schedule issue, but it flows from the fee schedule and potential bias on part of the doctor. No doctor should be forced to issue a report in a case where he or she has a bias against a particular administrator, carrier or employer. The Medical Unit may say the doctor shouldn't have a bias, but if in fact, the doctor has a bias, is he allowed to refuse the assignment? If he refuses the assignment, is he subject to any discipline or punitive action?

William Tappin, Esq. June 29, 2020
Tappin and Associates

This comment relates to Title 8 California Code of Regulations§ 9794(a)(1) and Title 8 California Code of Regulations§ 9795(b). Section 9794(a)(1) does not include costs of clerical expense to produce the report. Section 9795(b) indicates that "the fee for each medical-legal evaluation procedure includes reimbursement for the history and physical examination, review of records, preparation of a medical-legal report, including typing and transcription services, and overhead expenses."

This is consistent with the prior Title 8 California Code of Regulations § 9795 and the language has not been amended. This has been an ongoing issue as medical-legal providers have been disciplined and required to pay monies back relating to the inclusion of charges for clerical services to produce the report. This should be addressed as we're attempting to move forward with some additional clarity regarding what changes are allowed. Regulation 9794(a)(1) and 9796(b) should be amended to indicate clerical costs are in addition as opposed to being included in the scheduled fee. Doctors should not be disciplined or threatened with non-renewal of certification for billing for clerical costs associated with the production of the medical-legal report. The state audit of the Department of Workers' Compensation specifically indicated that the recertification process was used to discipline doctors. Many doctors, when they are audited, must reimburse to the defendant carrier the costs associated with production of the report by a typist. Obviously, it is not in the doctor's interest to litigate that issue because it may result

in his non-recertification and given the relative values costs a great deal in terms of litigation versus the amount of repayments involved.

Labor Code §4628(d) states:

"No amount may be charged in excess of the direct charges for the physician's professional services and the reasonable costs of laboratory examinations, diagnostic studies, and other medical tests, and reasonable costs of clerical expense necessary to producing the report. Direct charges for the physician's professional services shall include reasonable overhead expense." (emphasis added)

This comment relates exclusively to the "reasonable costs of clerical expense necessary to producing the report." The statute clearly indicates that the doctor is entitled to reasonable costs of clerical expense necessary to produce the report. This is clear and unambiguous language in Labor Code §4628(d). There is no misconstruing the meaning of that language.

Labor Code§ 5307.6 directs the administrative director to adopt and revise a fee schedule for medical-legal expense. There is no question that the administrative director has the authority to enact regulations to interpret the Labor Code. However, the enabling statute reflected in Labor Code§ 5307.6 is subject to limitations. California Government Code § 11342.2 states:

"Whenever by the express or implied terms of any statute a state agency has authority to adopt regulations to implement, interpret, make specific or otherwise carry out the provisions of the statute, no regulation adopted is valid or effective unless consistent and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute." (emphasis added)

In this particular case, the statute indicates clerical expenses necessary to produce the report are in addition to the medical-legal fee. Title 8 California Code of Regulations § 9795(b) is in conflict with the statutory requirements of Labor Code§ 4628(d). In addition, it does not effectuate the purpose of Labor Code§ 4628 and the legislative scheme surrounding that statute. With respect to medical-legal expenses, Labor Code

§ 4622(e)(2) states:

"The Appeals Board shall promulgate all necessary and reasonable rules and regulations to ensure compliance with this Section, and shall take such further steps as may be necessary to guarantee that the rules and regulations are enforced."

Labor Code§ 4622 is captioned "Employers' Liability for Expenses; Penalty." The

statutory scheme and intent in amending Labor Code § 4622 effective January 1, 2013 was to stem the outflow of panel Qualified Medical Examiners and Agreed Medical Examiners from the workers' compensation system by ensuring that they were paid timely and in a proper manner. Reading Labor Code § 4622 and 4628 in conjunction, the legislative intent is clear. There's no ambiguity in Labor Code§ 4628(d) when it says the clerical cost of preparing the report are in addition to the medical-legal providers professional time.

When the Appeals Board or the Courts interpret workers' compensation statutes the fundamental objective is to determine the legislature's intent so as to effectuate the purpose of the law. The best indicator of legislative intent is the clear, unambiguous, and plain meaning of the statutory language. In interpreting statutory provisions, the court will first look to the express language of the statutes themselves. When the statutory language is clear and unambiguous, the court will enforce the statute according to its plain terms. *(DuBois v. Workers' Compensation Appeals Board* (1993) 5 Cal. 4th 382 [58 Cal. Comp. Cases 286])

The DuBois case, supra, reflects the general administrative law rule that statutes have primacy over regulations. The regulations cannot be inconsistent with or contrary to the plain unambiguous language of the statute. In this case the clear unambiguous language of Labor Code§ 4628(d) is that the doctors are now, and have always been, entitled to the clerical cost for the preparation of a medical-legal report over and above the professional time charged. The unamended Title 8 California Code of Regulations

§ 9795(b) and the current amended 9795(b) are unquestionably inconsistent with the clear and express language of the statute and inconsistent with the intent of the legislature in enacting the statute. I won't go into detail in this comment relating to the documentation of the legislature's intention but can do so if the DWC desires.

In the en bane case of Mendoza v. Huntington Hospital/Sedgwick, the Appeals Board addressed a very similar issue. The question was whether an administrative director rule is invalid because it is inconsistent with Labor Code§§ 4060(c), 4062.2, and 5402(b). In that case, the Court was very specific. It stated when considering the validity of a regulation enacted by the Administrative Director, "Our task is to inquire into the legality of the ... regulation, not its wisdom." (Citing Moore) (Further citations omitted). The court cites Government Code § 11342-2 and states, "No regulation adopted is valid or effective unless consistent with and not in conflict with the statute." Please note in this case the statute was not the enabling statute but rather the underlying statutes of 4060, 4062.2 and 5402(b). They further cite additional cases which will not be specifically enumerated based on limitation of space that state "A regulation that is inconsistent with the statute it seeks to implement is invalid. (Esberg

v. Union Oil). There are numerous cases relating to agencies in addition to the Department of Workers' Compensation that have found a regulation is invalid on its face if it is inconsistent with the statute. An administrative agency has no discretion to promulgate a regulation that is inconsistent with the governing statutes. Administrative regulations which exceed the scope of the enabling statute are invalid and have no force or life. Administrative regulations may not contravene terms of statutes under which they are adopted. (Boehm and Associates v. Workers' Compensation Appeals Board (Lopez) 64 Cal Com Cases 1350).

In this particular matter, the proposed amended regulations mirror the prior regulations. Both the prior regulations and the current regulations are inconsistent with the intent of the legislature in enacting a scheme for payment of medical-legal providers and specifically in clear violation of the unambiguous language of Labor Code§ 4628(d).

The current amended regulations should reflect the intention of the legislature and the clear language of Labor Code§ 4628(d) and not perpetuate the errors reflected in the earlier version of Title 8 California Code of Regulations § 9795.

There are, many cases both within the workers' compensation system and other agencies that support this position. Administrative regulations that violate acts of legislature are void. (Daley 276 Cal.App. 2d 801). An administrative agency may not promulgate a rule or regulation that alters or enlarges the terms of a legislative enactment (Cleveland Chiropractic College 11 Cal.App. 3d 25).

In reviewing the proposed regulations, I note Title 8, California Code of Regulations

§ 9795(b), last sentence indicates:

"The complexity of the evaluation is the dominant factor determining the appropriate level of service under this section; the times to perform procedures is expected to vary due to clinical circumstances, and is therefore not the controlling factor in determining the appropriate level of service."

It seems, based upon the discussions about the fee schedule and the current "flat rate" process, that this sentence should be completely eliminated from Title 8, California Code of Regulations § 9795 consistent with the intent of the recent renumbering and clarifying of the regulations. This appears to relate only to the prior complexity factor analysis which is being replaced.

ML206 should be clarified further. The advocacy letter should state precise key points that the examiner should address as it is all too common for the requesting parties send generic letter with multiple questions.

Also, the examiner should only have to address the body parts in the agreed letter and not have to rely on the history of the patient.

Kari Tervo, Ph.D., QME June 29, 2020

I am getting really tired of writing you letters to beg to be adequately compensated for the complex medical-legal work that I do.

I'm sick of begging you to be reasonable for the sake of injured workers.

I'm frustrated that I have to keep trying to say the same thing in different ways every time you pull the stunt of not only failing to even give us our first cost-of-living increase since 2006, but actually *decreasing* our wages significantly and expecting us to work for low wages, or in some cases, for free.

This is ridiculous! What are you doing? You're intentionally trying to destroy the workers' compensation system from within, is how I see it. You want doctors to review records for free—disorganized ones at that. You want us to write supplementals for free. You're giving us a fee schedule that compensates California doctors less than Nevada doctors, when it's so much more expensive to live in California. What could possibly be going through your head?

I'm done with being polite. I'm done wasting my time trying to explain things you already know but don't care to acknowledge. Do your job, stop purposely making the workers' comp system hemorrhage QME doctors, and stop playing these ridiculous and insulting games with workers' lives and doctors' livelihoods and careers.

Knock it off. Give us a fee schedule that adequately compensates QME doctors for the complex work that we do. Stop expecting us to work for free. This is outlandish and ridiculous and immoral. Yes—immoral. Injured workers need timely medical care and QME doctors chose this career because it's a good fit for their skills, and you're playing games with everyone's life.

You're also forcing doctors to reconsider their career options in the middle of a pandemic and quarantine! It's unconscionable.

Stop. If you don't want to do the work and do the work fairly, hand it off to someone who actually cares about the injured workers of California and who has some respect for QME doctors, because it's clear on both counts that you don't.

I do not want to have to write another letter like this. I'm sick of fighting about this. I just want to do my job and be treated fairly. DO. THE. RIGHT. THING.

Keith Bridges June 29, 2020

If DWC wishes to adopt a set fee structure similar to the one used in Nevada, then the pay rate should be 15% higher than Nevada to reflect higher overhead costs in California. Cost of living increases in payment should be automatic. Carrier requirements should be the same as Nevada.

Emily Todd, MD, PhD, QME June 29, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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This proposal will be the final straw for many providers, including myself.

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Dinesh Sharma MD June 29, 2020

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I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported

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Dr. Louis Rosen June 28, 2020
Physical Medicine & Rehabilitation

The proposed changes are unacceptable. I am a newer panel QME, and I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California. Also, I am baffled that you have not included a COLA, an essential requirement for the QME community.

I am a new QME, recently listed with the State, and was optimistic that the fee schedules would be resolved in a fair and equitable outcome despite all of these issues. I am not so sure now, and am questioning my involvement with the California DWC QME system

This proposal will be the final straw for many QME providers, including myself.
I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

Thank you for your reconsideration of the currently disappointing and unacceptable proposed QME fee schedule change. In addition to a more equitable reimbursement rate, a COLA must also be included.

Alireza Esfahane, MD, MSCR, QME June 28, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

Sue Honor's proposal and the accompanying petition can be found here: https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality

physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.
I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

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Anonymous June 28, 2020

The proposed regulations are again terrible.

As everyone knows, the DWC used underground regulations to go after QMEs and were found to be in the wrong by the District court. The QME thought everything was fine now because the DWC was to follow the laws and rules as written. Then, the DWC gave their first proposal for a fee schedule and it appeared to be in retaliation to the unjust conduct of the DWC. Then, the DWC proposed another fee schedule that appeared to be a cut to the QME fees. Many pointed out that they DWC was trying to get the QME into a system like Nevada. The DWC did not want to tell the community where they got the second fee schedule from, but it was later found out that it came directly from an insurance company. That confirmed what everyone already knows, which is the DWC is biased towards the insurance carriers. So, the DWC has been antagonistic towards QMEs on an ongoing basis.

There was an audit of the DWC. The audit showed different areas where the DWC had gone wrong and indicated there should be a rate increase and compensation based upon quality.

After terrorizing the QME community and acting in bad faith, some in the QME community acquiesced and decided to try to work with the DWC on a new schedule. The current schedule is superior because it is equitable to all specialties and values a QME's time. The workers could be heard, research could be conducted, reports could be prepared considering all the issues because it was compensated for, and the records could be reviewed adequately. However, some QMEs mistakenly felt that bargaining with the DWC would prevent an even worse schedule being proposed for a next round. For this current proposal, the DWC made some effort to try to have the appearance of some sort of process for coming up with new fee schedule recommendations at a stakeholder meeting. However, the process was poor and not everyone in the QME community were notified about this and given an opportunity to participate. It was just certain groups coming together to force a consensus. The payers had an outsized voice

and did not consider suggestions for pay increases based on quality, the amount of work, and the fact that QME rates have not gone up in a very long time. The negotiations were based on supply and demand of QMEs. There was an undersupply for orthopedists, so the payers agreed to boost pay for ML 102 and ML103 evaluations to get more orthopedists. However, for the mental health specialties, the payors said there was an oversupply or psychologists, and rather than negotiate based upon the complexity of the evaluations, there was only a low multiplier assigned because the payors had no problems getting a psychology panel. Also, for psychology, the meeting was surprisingly short and occurred late when everyone was tired and wanted to go home. There was no adequate consideration for complicated issues facing mental health. There were also persons who had no idea what mental health did vote on the mental health multiplier. For example, an orthopedic representative voted for the lower multiplier and admitted having no understanding of why mental health evaluations took as long as they did. The mental health stakeholder meeting was initially characterized as a sham. At the stakeholder meeting, there was also no adequate representation for QMEs that do complicated reports. There was no discussion of a multiplier for complicated evaluations. There was no discussion that the number of records provided to a QME does not equate to complexity and that some of the most complicated cases come with the fewest records while taking the most time.

The DWC's current proposal not only put into place parts of the poor outcomes from the stakeholder's meeting but also incorporates other factors that essentially destroy the quality of the Worker's Compensation system.

Those doctors that are for this proposal likely like it because they are going from being poorly reimbursed under ML 102 and 103 to a higher minimum flat fee of 2,015 dollars. However, they probably don't realize that they are being paid less than the Nevada schedule. Under the Nevada schedule, an evaluator will get 1784.12 dollars for a flat fee and this includes 50 pages. Above 50 pages, you get 4.46 dollars for each page reviewed and then an additional 0.97 cents for organizing records. So, for an evaluation with 200 pages of records, you will get under the Nevada schedule, assuming records were provided in chronological order, 1784.12 + 4.46(150) = 2451.12 dollars. Under the Nevada schedule, if you were given pages out of chronological order, a QME would get 1784.12 + 4.46(150) + 200(0.97) = 2645.12 dollars. So that is already, over 600-dollar less that a QME would get from high cost California versus lower cost Nevada.
For California, the reimbursement for reviewing records between the number of pages from 201 to 1000 is 3 dollars. Then, it is two dollars from pages 1001 and above. For lower cost Nevada, you continue to get 4.46 dollar per page above page 51 and then 0.97 cents to put those in chronological order. So basically, QMEs in California, are given a much lower reimbursement as cases increase in the complexity and numbers of records than in lower cost Nevada.

For Nevada, the number of pages sent to the QME is specified. For California, this is not specified, and the QME must spend a significant amount of uncompensated time counting pages.

We can also see how the DWC is trying to get the cost even below lower cost Nevada in failed appointment fees. For Nevada, the failed appointment fee is 669.04 dollars. For California, the proposal is 504 dollars. We know that many carriers are currently taking advantage of QMEs by not paying any failed appointment fee or a fraction of a failed appointment fee. Also, a mental health professional loses much more when someone fails an appointment because a whole day may need to be reserved and that entire day is lost. A non-mental health professional may lose an hour of face to face time or possibly less. There is no justification for giving less compensation to non-Nevada physicians and to mental health professionals.

In Nevada, they pay 325.41 dollars for each body part evaluated in excess of the first two. For the DWC proposal, it is zero. So, we can see again, that for complex evaluations, the DWC proposes paying less than Nevada.
For Nevada, they have an automatic COLA increase. For California, the DWC proposes no COLA increase. The DWC has gotten away with underpaying QMEs for a long time and with the proposed schedule, they can get away with another decade without addressing underpayment.

The psych multiplier is unacceptably low. The proposal pays mental health professionals at a rate of 1.6 times what non mental health evaluators will get. Non mental health evaluators can easily do two or three evaluations or more in the time it takes for a mental health professional do one evaluation. A mental health professional can take two or three times as long or more to evaluate a patient, review records, and compose as report than a professional in another specialty. It is not uncommon for just face to face evaluations along with testing to take an entire day. This is without record review, scoring testing, analyzing the data, and composing a report. There is simply much more data that needs to be evaluated and taken into consideration for a mental health professional. Because the law is designed to deny as many mental health claims as possible as compared to other specialties, mental health professionals have to take much longer evaluating industrial and non-industrial factors, determining predominant cause, considering personnel action, dealing with apportionment, a Rolda analysis, etc. Again, the faulty stakeholder meeting did not consider these factors and did not have adequate/sophisticated persons with knowledge about what mental health professionals do when considering the low multiplier of 1.6. So mental health professionals are left with this supply and demand multiplier that regardless of the amount of work, the payors will not pay more because it is easy for them to get a panel. Therefore, mental health professionals are not being paid equally to other physicians and there is no justification of it based upon work. Mental health reports are more than 1.6 times more complicated than regular reports and are actually likely 2 ½ times to 3 times or more complicated.

Also, for mental health evaluations, every human on this planet is different, brings in different life experiences, and has different experiences at work. Initially, they may be referred as someone suffering from mental health issues form an orthopedic claim but then they may start taking about 10 years of being sexually harassed, but no one took the time to talk to them. So, a multiplier is inappropriate for mental health and the current schedule is superior in capturing the time and considerations necessary for mental health evaluations.

There is no multiplier for complicated cases. For example, there are complicated orthopedic, neurologic, internal medicine, toxicology, and other cases. All specialists can have complicated cases. They require talking to a patient for a long time, a careful review of the records, and a detailed report. However, again, there is no incentive for reports reflecting the complicated issues to be produced. This means less time exploring non-industrial causes of injuries. This means less time in giving a thoughtful analysis as to why an injury might be industrially related. Since records are to be reviewed at 100 pages an hour, even for complicated evaluations, that means many pertinent and useful information will be missed.

What is also egregious is that if a case requires any research, the DWC has cut off compensating for research. That means if a patient had a toxic exposure, the QME is not incentivized to adequately research the patient's case. A patient may have developed cancer from a chemical that was only recently been found to cause cancer and the research helps to support that was the cause. Research helps to strengthen opinions and because medicine evolves, it is necessary that updated research be used when evaluating the effectiveness of treatment, the appropriateness of treatment, and future medical recommendations. On the Federal level, as part of the Daubert standard, scientific knowledge of experts is based upon whether it has been subjected to peer review and publication. So now that the DWC wants to unilaterally not compensate for research, the entire Workers' Compensation system will change to less scientifically sound reports. To access quality research, QMEs often have to pay money for that research. QMEs would be less willing to pay, at a loss, for research that may be necessary for someone's case. So, the result of this is that the reports will be of poorer quality because the opinions will be less scientifically sound. Given that attorneys in the current system rarely challenge QME reports based upon substantial medical evidence, these low-quality reports will become the norm. This fee schedule would benefit from a legal challenge based upon non compensation of research alone.

What is also bizarre about this proposal is that QMEs are responsible for counting pages. For how long are QME's going to be responsible for holding onto all of their records if there is a page count challenge by the insurance carriers? Who pays for that storage cost? How come all the additional time it will take to count all the records is not compensated for?

I also note that there is a proposal for remedial supplemental reports where a QME may be forced to do a supplemental report without being paid if it is determined that a question should have been answered in an original report. So, if asked to do a supplemental report, a QME may be working for free or face discipline.

So, what does this all mean for a patient? Well, all the quality controls have been tossed out the window by the DWC. There are no complexity factors for causation, apportionment, research, record review, or face to face time. This means the QME has no incentive to see patients to explore all the pertinent issues. If you are a patient, that means that if there are other body parts that are part of your claim that were not addressed, the QME has no motivation to address that and there is now a financial incentive not to address other issues. In the current system, the concern is for fraud by overbilling. Well, the motivation here is for fraud by performing substandard work. The faster the evaluation and the smaller the report, under the new system, the more per hour a QME will get. So that is great for an ML 102 and ML 103 evaluator because now, without having to think about addressing issues based on complexity, you can see many more people in a typical week and get much more pay for less work. Another problem for patients is that because QMEs are now motivated to give barebones reports under the new proposal, there will be more depositions and requests for supplemental reports. The good thing for those doing these barebones reports is that because attorneys don't want to challenge reports based upon them being substantial medical evidence, they will become the low-quality standard. Patients will likely be part of a patient mill. That means the QME will schedule patients for a short appointment, ask relatively few questions, will not be motivated to talk to you in any great detail, and then generate a fast report that may have profound impact on your life and you have little recourse. Patients probably would do best by advocating for their Primary Treating Physician's report be taken into greater consideration than a QME report because at least, although a Primary Treating physician lacks the neutrality of a QME, has seen the patient for a longer period of time while the QME may have a shoddy report analogous to some of these medication reviewer reports.

If a patient has a complicated injury or injuries, a continuous trauma or traumas, a harassment claim, a first responder with a lengthy injury history, etc, that patient is especially harmed under this system. Patients first have to face all the factors listed under the previous paragraph. There is no financial incentive for a QME to spend any extra time to talk to a patient about the injury or injuries. If the patient is a first responder, the QME will be disincentivized to spend more time with a patient to talk about all the factors you think are pertinent to their claim. The QME does not have to spend more time addressing issues of causation or apportionment. The QME does get any more money producing a 10-page report versus a 20-page report. The sickest patients do the worst under this schedule because after 2000 pages, the QME is getting paid less to review your records. The current model is based upon paying QMEs per hour to review records. That means the QME can spend time to review the records and

think of the complexities of a case. The DWC is proposing a record review of 100 pages per hour. Can you imagine trying to review records for a complicated, or even a simple case, at 100 pages per hour? Remember, the QME has to read all of your records and try to put them in some sort of order to make sense of them. Basically, the more time a QME spends with a patient and producing their report, the less the QME makes. So, if the patient gets an unsupported opinion, that patient may be stuck with that faulty opinion, or the patient may be subjected to months or years of delay to resolve the issue.

For a mental health patient, they should be concerned that the DWC and the stakeholders did not take the stakeholder's meeting seriously. They should be concerned that the evaluator will not get any more compensation listening to your six-hour history as they would a one-hour history. For example, if a patient has a harassment claim and needs hours to talk about how they were sexually harassed at work, the QME has no financial incentive to go through that because they get the same pay regardless of if they spend 6 hours with a patient or 1 hour with a patient. On the other side, they should be concerned that non-industrial factors will not be significantly explored.

Would deposing a QME will help? Well, QMEs are supposed to get paid per hour of deposition preparation and deposition time. Because of the DWC, QMEs are paid one hour of preparation time and one hour of deposition time. The lawyers will pay QMEs more if QMEs spend more hours in actual deposition time but will not pay QMEs more even if there is more preparation time, even for complicated cases. That is, the DWC will back the low payment of 1 hour of preparation time despite the number of hours it takes to prepare a case. So, in addition to lower quality evaluations and reports, there is no additional incentive for a QME to prepare for and provide a higher quality deposition. Some doctors have tried to sell the DWC proposal saying that for some reports the QME will lose money and for some reports, the QME will profit. The idea is that, in the end, the doctor will have overall gains. A patient does don't want to be viewed by their doctor as a patient that will cause the doctor to lose money. This is systemic discrimination based upon the type of injury being introduced by the DWC. That will mean these patients reports are more likely to be of lesser quality and the doctor will want to spend much less time on these cases. It may be that offices from doctors will start asking screening questions to determine which patients will cause them to lose money. One remedy, other than paying doctors for the actual time they spend on a case, to this is to allow QMEs to refuse cases. Unfortunately, applicant attorneys did not allow for that and this forces doctors to have a financial loss. We know that applicant attorneys can choose what cases they have to take on based on financial considerations and can choose to no longer represent them after they are permanent and stationary, leaving patients to essentially navigate the system by themselves for the rest of their life. So, there is an inherent hypocrisy in that position that ultimately harms patients. The DWC is therefore knowingly underpaying QME doctors for certain cases

and the QME will have to accept them no matter what. It would be interesting to know what other state administered system knowingly allows underpayment to those performing work. A properly incentivized system would allow all claims to be paid at a rate there is no loss. This would be good grounds for a legal challenge.

We are also talking about diversity nationwide. We know that the lower rates will lead to decreases in the ability for doctors to be able to provide QMEs near underserved areas. We know that the QME population lacks a significant amount of diversity and those specialties hit hardest by this proposal will face even more significant declines in representation. We can already see that for some areas, there are no treaters in various specialties because of how the DWC gutted the treatment system. With this proposal, QME's will find it more financially difficult to travel to satellite offices to perform evaluations.

In summary, they DWC wants to change the system. They want to cut the amount paid for reports but are willing to increase incentives for specialties they need such as orthopedics, while simultaneously, still keep payments for these specialties lower than neighboring lower cost Nevada. The DWC has been constantly targeting the ML 104 under the guise of tacking overbilling. However, the new proposal ushers in a nefarious form of overbilling by providing fast and substandard evaluations. The clear losers in this are patients, especially those that have complicated claims, and those QMEs that want to do quality work that recognized that many evaluations take time. The clear losers are also judges who will have the following: less scientifically sound reports, reports that cut corners to maximize profits, the delay in processing claims because of the need to do additional depositions and supplementals, and the admission into evidence far more reports that are not substantial medical evidence because the parties clearly are not interested in challenging reports. The clear winners are the DWC, those who will do substandard reports, and the payers. The DWC has been aligned with payers for a long time to help them deal with cutting the cost of complicated patients and their associated complicated reports.

All QME are also the loser because the DWC is still in a QMEs life in a major way because they are asking the QME to count pages and to do supplemental reports deemed to be remedial, for free. The end result is that while more people can be seen, and the system is harmed by an increasing number of low-quality reports.

The current schedule did not nothing to address fraud and overbilling because the new incentive is to overbill by doing much less work. The stakeholder meeting should be audited. This proposal, if implemented, would benefit from legal challenges. It would benefit from an analysis as to why doctors, who do complicated evaluations, will get paid less per hour, than doctors doing less complicated evaluations. It would benefit from being examined as to why there are no quality modifiers, no COLA increase and no overall increase in rates. It would be interesting to know why, when the DWC was

aware of the Nevada scheduled last time around, chose to propose this current schedule to reimburse much less than lower cost Nevada does. The proposal would also benefit from a scrutiny as to why there is no parity between medical legal experts in the Workers' Compensation system as opposed to outside the Workers' Compensation system as required by law.

There current schedule is a superior to the proposed schedule in every way, and to make this a better system, the DWC should work on not trying to change the system as often as they are and treating QMEs fairly. They are already losing QMEs left and right and irreparably harming the entire Workers' Compensation system from at all levels from treatment to medial legal examinations.

Stewart Lonky, MD June 28, 2020

I have just finished doing a number of supplemental reports for cases I saw in the past. They each required more than 3 hours of medical research as well as a review of prior reports by me. More than 4 hours each. While I learned a lot, I have no desire for your proposal to underpay me for my time and research. The flat fee of $650 is insulting.

There needs to be an increase of the base for Internal Medicine doctors. We get very complex cases, and the amount of time required and the effort required to do a reasonable job for both the patient and the insurer demands a higher base amount for the initial report here. The base needs to be increased to a level 1.5 above what is proposed.

I would suggest that all the meetings and hearings you have had with stakeholders have not really moved DWC far from its original proposal. This is still NOT A RAISE after 14 years. It looks like the insurance companies continue to win, and I am really concerned that the good/quality doctors will leave this system. The reports you will get will be lacking quality, and in the end you will pay more for appeals and re-evaluations. Please do not be so short-sighted. Give us what we have earned by waiting for all these years; reasonable pay for the job(s) we do. Rewarding "toxicologists" and "oncologists" is a bit of a joke. As a pulmonologist, half of my cases are toxicology, and I spent more years training than any toxicologist! And, I am far more capable of rendering more "inclusive" diagnostic impression than any toxicology "specialist".

Dr. Pamela V. Ford, D.C., Q.M.E. June 28, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

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The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.
I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Roy Curry June 28, 2020

[Note: Roy Curry is responding to Mr. Lieberman's comment below.]

Jacob Rosenberg June 28, 2020

[Note: Mr. Rosenberg is responding to Mr. Lieberman's comment directly below.]

I agree with you.
There is an extraordinary lack of institutional respect from payers and the DWC about how complex evaluations require sophisticated, knowledgeable, experienced, nuanced evaluators.

Then they complain about poor quality reporting (which is an issue) but fail to have any plan (or desire) to reward evaluators for doing extraordinary complex work.

I can tell you that Mike Post and I raised these issues at the stakeholder meetings
The resistance to continuing the (token)25% AME modifier was astounding. After an hour we prevailed (making arguments similar to your points)
Now we find the DWC ignored the stakeholder consensus and rolled us back to a flat $700 bump regardless of how complex an evaluation is.

But this isn't over. Make your points on the DWC website, send a letter to khagen@dir.ca.gov and write your assemblyman. If we all do this then we will get changes.

If only a few respond then the DWC will assume it is safe to proceed
I'm doing my best for CSIMS members but more help is always welcome.

For the first time I can remember we have a lobbyist who is effective. Think back to the schedule published last August. This is much better

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Richard Lieberman MD June 28, 2020
Associate Clinical Professor
UCSF, San Francisco

I have been an AME since 1994, having examined several thousand people, and, together with my few remaining senior psychiatric (medical doctor) colleagues still doing this work, we have saved the insurance industry and the state of California millions of dollars by addressing four tasks assigned specifically AMEs, not QMEs.1..to provide a comprehensive medical record review, (unassignable to non MD QMEs) in reviewing complex medical and psychiatric sequelae from injuries involving ALL specialties, not just orthopedics and pain management, 2. to explain in detail how and why we came to the conclusions we did, facing deposition otherwise to push this, appropriately, towards closure of the case, 3.to address causation of injury, disability, and apportionment, 4 to

recommend timely and appropriate treatment where indicated, immediately helping to finalize the case. Medical and nonmedical QMEs are not required to address this set of complex assignments with full accountability. There is a quantum difference in the assignments to the QME and AME. Hence, with the obvious coming elimination of AME psychiatric and other specialties, such as neurology and neuropsychology, reflected in the new fee schedule, the costs to settle a case and the endless and ineffective treatment currently rampant in the system, will rise geometrically. The AME system was designed to expedite and finalize complex situations where injuries are serious enough and chronic to involve multiple specialties to bring to an end unnecessary expenditures to close out these cases. To save money. And it worked.

I see no evidence anywhere of any sensitivity to this historical argument by the DWC, especially as it pertains to the few remaining psychiatric AME physicians, such as myself, who will undoubtedly retire from this venue for lack of recognition of unique assistance we have provided to injured workers. No, it is not the failure to increase the fee for these services to which I object, it is the absolute neglect of the value we have brought to patients, insurance companies, and litigating attorneys through savings and timely care which will now be lost forever. Our contribution is being eviscerated.

The insensitivity is remarkable with respect to this , for as an ex president of CSIMS, 2013, I have yet to see any, any comment from anyone on this subject, in dialogue publically, other than senior applicant and defense attorneys who agree completely with what is written here.

Dr. Mikiko Murakami June 28, 2020

The proposed changes to reduce the current fee schedule for physicians is not acceptable.

I would like to be able to continue serving as a QME; these new proposed changes do not take into consideration my costs to serve each report.

At bare minimum, I would like to propose that no changes be made to the current fee schedule, and if possible, I would like for the following to be considered:

- Sue Honor's proposed fee schedule - this has received > 2,750 signatures from the community.

- The cost of inflation to be added on to the current fee schedule

And although not payment related, it would be very cost and time efficient for everyone involved if:

- All reports, records and correspondences could be done digitally. The current regulation regarding electronic transmission of reports have been helpful!

- If the DWC could create a software to avoid multiple data entry. Currently, there is a lot of wasted time with the same data being entered by every party, with errors being made in the process. I would love to help with this if there is a need.

Thank you for your consideration and attention to this matter.

Alan Rashkin, MD June 28, 2020

I am concerned that the recent proposed changes, which were not the ones previously agreed upon, will harm my practice and ability to continue with future QME participation.

I urge you to replace this proposal with Sue Honor's proposal. If the fee schedule is changed, I will harm my practice and other QME's and it is very important that fair reimbursement for the time spent will permit QME physicians to continue working for the Department of Industrial Relations in California.

Karl Robinson June 28, 2020

Hello, and thank you for taking the time to listen to my concerns about the new proposed fee schedules. My principal concern and reviewing these new proposals is that there appears to be a significant reduction and reimbursements for the same services that we have need providing.

I certainly hope we can take the time to take into consideration these concerns that I have. Firstly, $2 a page over a 1,000 pages is is less than what is currently accepted and therefore requiring QME physicians to take a pay reduction when handling complex cases with lengthy medical records. Second, under the new proposed fee schedule we do not get paid for lengthy face to face time or needed medical research. Certain complex cases with multiple injured body parts will require lengthy face-to-face time above 2 to 3 hours. That results in the physician working without compensation for time spent with the applicant. Additionally, to give an updated and research validated answer to certain questions on causation and return to work, and assessment of a medical

research is necessary. Yet with the new proposed fee schedule any additional research will not be reimbursed. Thirdly, the new proposed fee schedule does not take into account cost of living increase, in fact is a pay decrease. Home values in my neighborhood have increased by an average of over 70% of the past 14 years, yet QME reimbursements have stayed the same, and in the proposed schedules are being actually reduced.

I would hope you could reconsider these concerns when taking into account any finalized changes. Taking all this into consideration, and the amount of time and effort that goes into providing quality reports, if this new fee schedule goes into effect as has been proposed, I am fairly certain I will not continue to operate as a QME.

Thank you for taking the time to listen to my concerns.

Meghan Marcum, PsyD, ABPP, QME June 28, 2020

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Sloane Blair MD, QME June 28, 2020

I am a QME for more than 15 years. While I am glad to see there is some effort to improve QMEs in the State of California, the new proposal has problematic issues. The specific issues are uncompensated time.

Allowing insurance companies to decide if we should be reimbursed for supplements is akin to letting the wolf guard the henhouse. There is no motivation for them to pay us fairly or at all. It is a business. The barrier has to be the DWC. I don't understand why the DWC treats lawyers so well, in terms of reimbursement, and treats doctors relatively poorly.

Allowing an unlimited number of add on body parts also expects us to do uncompensated work. I cannot understand or discern why we are again expected to offer uncompensated work.

This is a sure path to poorer quality and fewer QMEs. If I have a sloppy, out of order record review dumped on my lap, and I am not reimbursed for sorting that review, I will review it as presented to me. It will result in lack of clear and sequential thought. I will blame you and the insurance companies.

While COVID 19 may result in perhaps an increase in QMEs to compensate for the decline in our practices, this will not last forever. Medicine is partly a business too, and the components with the most aggravation, least joy and least money will rise to the top to be eliminated once elective care normalizes. Look at the delays you have now, and difficulties scheduling. The new fee schedule will make that worse.

Of the 3 components of the QME, 2 are very profitable, doing well, and have a supply of participants that exceeds demand. Those 2 are the lawyers and the insurance companies. Again, I don't understand what you have against the medical providers, but even on its face it seems unfair that we are singled out.

Again, thank you for the effort, and the positive parts of the proposal.

Perminder Bhatia June 27, 2020

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Dr. Bob Chen June 27, 2020

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Jamie Rotonfsky, PhD, QME June 27, 2020

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I believe even Sue Honor's Propsoal does not even go far enough. The proposed new fee schedule is absurd, lower than current QME billing rates which have not been increased in decades. This is unacceptable and as usual benefits the insurance companies and not the applicants or QME's as the system will be no longer be effective in addressing applicant needs as many of the existing QME's will discontinue including me. This will make it even harder for an applicant to be assessed, Perhaps this is the purpose.

Michael Bazel, MD June 27, 2020

The new rules are concerning to me. It seems DWC is trying to get QME's work for free at the time, when most doctors are leaving the specialty. There's no cost of living

increase and reimbursement per page is much lower than other States. There're some instances, which would require QME produce reports for free.

In addition, I would like to see recommendations on how to document Medical-Legal reports done by PTP.

Arsalan Malik, M.D.
Private Practice of Psychiatry
Diplomate, American Board of Psychiatry & Neurology
Diplomate, American Board of Integrative & Holistic Medicine
Clinical Associate, New Center for Psychoanalysis
Clinical Instructor, UCLA Department of Psychiatry
Qualified Medical Examiner

June 27, 2020

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Tigran Garabekyan, M.D. June 27, 2020
Board Certified Orthopedic Surgeon
Sports Medicine and Joint Replacement
Southern California Hip Institute

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Carol W. Fetterman, Ph.D., Q.M.E. June 27, 2020

After the meetings which took place between insurance payor and QME's over the past several months, general reimbursement levels and terms were agreed upon for the most part, although the DWC's flat fee proposal has never been accepted for psychological/psychiatric evaluations. Even though the proposed fees were agreed upon by the other disciplines, the DWC is again reneging and proposing reimbursements that are less than those agreed upon.

Furthermore, the particular issues inherent in psychological evaluations have yet to be acknowledged by DWC.

It appears that the rate for Psychological evaluations is actually a reduction of the current fee structure **and for most cases would reduce payment**.

Therefore, this portion of the proposed fee schedule should be addressed to also provide an **increase for Psychologic evaluations**. Psychologic evaluations are 2-3 times the length of most medical examinations and are inclusive of many more factors which bridge both the medical events of a claimed injury and the Psychological/personnel claims being made.

It makes no sense to cap the time arbitrarily that the QME will be compensated for a psychiatric report. There is a great variety in the complexity of cases, resulting in vast differences in the amount of time needed to obtain information. It is completely unreasonable to expect a complex exam with the Injured worker to be completed [which takes 4-6 hour face time] along with the review of records which should or could include medical, psychological, personnel and Investigative records **and to pay less for this service**.

There is a wide variance in amounts of records received. Not all these categories of records apply to all of the cases, and even when they are needed, frequently very few records are provided. Therefore the added rate per page is an uncertain modifier as no provider ever knows how many records will actually be received. To base the fee for a report in large part of the number of pages provided, does make sense in these type of reports. The Psychologic cases should have a modifier of at least 2.5 of the base rate to

become close to what is *currently charged* for these cases, let alone see an increase which is the purpose of the committee's recommendation.

Capping the time spent on initial and supplemental reports, regardless of the amount of records or the complexity of issues being requested will likely result in psychologists and psychiatrist QME not being willing to take complex cases or spending the time needed to write a thorough and comprehensive report.

As a psychologist, the volume of psychiatric evaluations I receive is very small; usually no more than one per month.. However, because of the complexity of the cases I do receive, I am often required to write ML 102, ML 103, and ML 104 evaluations. The proposed fees for these evaluations are woefully inadequate.

In conclusion, the main consideration should be that psychological evaluations are very different from physical evaluations. They are different in complexity, in the amount of time it takes to do them, and in the fact that typically psychologists/psychiatrists receive only a fraction of the medical records that the other disciplines do.

Emily B. Fine, Ph.D. June 27, 2020
Licensed Psychologist
Clinical Neuropsychologist
Qualifed Medical Evaluator

The proposed QME fee schedule changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

Many quality doctors have quit serving as a QME, or have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues. This proposal will be the final straw for many providers, particularly psychologists and psychiatrists, who will be adversely affected the most.

I urge you to replace this proposal with one where QMEs from all disciplines will receive an increase in reimbursement for all QME services provided.

Dr. Bruce Roth June 27,2020
QME Psyciatrist

The proposed changes are unacceptable and will lead to a major loss of QME providers.

I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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David A. Sami MD June 27, 2020

Though I appreciate the efforts by the DWC to address deficiencies in the med-legal fee schedule, once again the proposed changes have a net effect of reducing the overall re-imbursement and fail to impose penalties for management companies and insurers who abuse the system.

1. The new fee schedule imposes a $500 penalty for a missed appointment, but at the same time values a comprehensive med legal eval (including 200 pages of records review) at $2000.

   Writing a well thought out and researched report takes at least 10-12 hours, and more so if there are multiple risk factors or injuries / exposures to consider.

   I presume the $500 missed appointment penalty is to compensate the physician for the 1-2 hours (average of 1.5 Hrs) of time and preparation that is set aside for each applicant. On this basis the minimum compensation for a comprehensive med-legal eval should be at least 8 x the missed appointment rate: Namely $ 4000. Further, there needs to be a cost of living adjustment (e.g. 5% every 2 years) in the fee schedule.

2. There is no explanation as to the reasoning behind reducing payment for records review over 2000 pages. If anything it should be higher, since organizing, collating, cross-referencing of records becomes increasing more difficult with increasing volume of pages.

   At minimum the reimbursement for additional pages over 2000 should be reimbursed at a similar $3 per page rate, not less.

3. There is not an explanation in the proposed schedule of how the records summary is expected in the physician report. Only that the physician is to "include in the report a verification under the penalty of perjury of the total number of pages reviewed by the physician as part of the medical-legal evaluation"

   I would propose the responsibility of counting the number of pages should fall with the insurance carrier. This way no party is at risk of perjury and the insurer has no reason to dispute the page count. As part of the evaluation the insurer should provide a detailed listing of records and page count for the physician.

4. There should be an explanation as to why Psychiatrists, Psychologists, Oncologists, and Toxicologists have been singled out as specialties that deserve higher reimbursement.

5. What is the rational for the description of ML202 as follow-up "which occurs within 24 months of the date on which a prior comprehensive medical legal evaluation was performed."

   Per labor code 9785 Permanent and stationary is described as the point where the applicant's "condition is well stabilized and unlikely to change substantially in the next year with or without medical treatment." When a "follow-up" is requested that is greater than 1 year from the initial / prior evaluation, it is generally because the applicant was deemed to be permanent and stationary, but subsequently had a change is status or other complications that necessitated a repeat evaluation.

   Follow up evaluations should be limited to re-evaluations that are within 1 year or less of the prior evaluation. Any evaluation that is more than 1 year from the prior evaluation should be excluded from the ML202 designation.

6. The description of ML205 is confusing. Does the fee for reviewing Sub Rosa recordings include the time spent to discuss changes to prior discussions of apportionment and disability rating? Is this not a supplemental report? What happens when a Sub Rosa film is received along with additional records and a request to submit a supplemental report?

7. The description of ML206 needs further clarification. In particular what agent or who determines under section (3) whether or not the physician is "addressing an issue that should have been addressed in a prior comprehensive medical legal evaluation, a prior follow-up medical evaluation or a prior supplemental…"

8. There is no mention of research / references to support the diagnoses, causation, apportionment and future medical considerations.

   Has the time spent for research been entirely removed from the fee schedule? Has the standard for references to establish "substantial medical evidence" in med-legal reporting changed?

9. Page 4 section 9794 (b) states that all medical legal expenses shall be paid within 60 days after receipt by the employer of the reports and documents…. Is there a penalty if payment is not made within 60 days? And if so is there a mechanism to enforce it?

10. A physician should be given the right to refuse requested evaluations by an insurer who has demonstrated a consistent and repeated pattern or denying payments. There should be a mechanism to report the abuse to an entity that is not aligned with the insurance companies.

James L. Deck, Ph.D., QME June 27, 2020

After 33 years of doing evaluations, this again proves that the Insurance Carriers control the system to the great detriment of all injured worker Applicants.

David W. Baum M.D. June 27, 2020

I am pleased that a reasonable med-legal fee schedule is finally being proposed. A fair updated fee schedule will salvage the workers' compensation from inevitable attrition and ultimate elimination. Young physicians might also be attracted to workers' compensation; although, understand that indoctrination to the procedures, case law and report writing is a steep learning curve which takes years. Finally, you have proposed a fee-schedule which will no longer anger the few remaining QME and AME physicians, most of whom invest themselves in their workers' compensation activities to the best of their ability.

As an internist, I propose several ideas for your consideration:

1) I am of required to invest extraordinary time addressing four to eight claims. My report must be responsive, regardless of the foundation for these claims. If a report requires that more than three body parts or systemic disorders be addressed, the fee schedule should include an accommodation;

2) In the case of highly unusual disorders requiring extensive medical research, a complexity factor should be introduced. As an example, a systemic parasitic disorder caused by a bat in a claimant whose job requires exposure to bat excrement;

3) A cost of living adjustment is expected . There has been no change in the medical-legal fee schedule since 2006. It is not difficult to envision the proposed medical-legal fee schedule in perpetuity. A cost-of-living increase commensurate with the increase in, for example, social security compensation, should be considered.

Thank you for your anticipated assistance and cooperation.

Steward Lonky, M.D., F.A.C.P. June 26, 2020

I am a QME and have been since 1995. I recognize you want to simplify the fee schedule, but you have grossly underestimated the complex issues faced by Internal Medicine doctors when they evaluate patients. The cases are frequently convoluted, complex, and require some degree of literature research. Even tho there is no requirement for research or credit given for research, most of us will be doing it anyway. I always have and can't see this stopping. There are detailed histories that need to be taken, with extensive past histories, family histories, and a detailed recounting of medications used during the course of employment (and afterwards) to be certain that what we are seeing as internal medicine impairments aren't just medication side effects or interactions. There is also a need to evaluate lab data, radiographic data, and heart and lung test data. In short, it is very time consuming.

I believe there must be an increase in the base pay rate for internal medicine cases, and I believe that a 1.5 multiplier is warranted on the base fee, and an increase in the per-page rate to $3.50 per page up to 2000 pages and $2.50 for pages 2,000+. I do not believe this "page rate" should be lowered.

The current proposal is disrespectful of internal medicine doctors, and diminishes their commitment to "getting it right" for both parties. The time in weighing all the issues in a case is worthy of this increase in reimbursement.

By keeping the current proposal you will fail to give us any increase in reimbursement. The fee schedule revision was undertaken to recognize the lack of any raise for us for over 12 years. You have failed to meet your promised obligation to give us an increase in reimbursement with the current recommendations.

Thank you for your time and understanding.

Max Matos, M.D. June 26, 2020

I believe the proposed fee schedule is adequate for the most part. I am writing to offer my input and recommendations as follows:

- I disagree with the following requirement for a reimbursable ML203, supplemental report as follows.

  (2) addressing an issue that was requested by a party to the action to be addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation.

It should not be enough for the parties to request the issue to be addressed. If I do not have the necessary documentation to give my opinion on the issue then I should be able to get compensated when I get what I need to issue my opinion. Oftentimes, for example, I cannot address apportionment even though I have been asked to, because I need the images of previous studies. If all the necessary information has been provided to the evaluator, then the supplemental report should not be separately reimbursable but, when we are getting piece meal information and we have to issue a supplemental report then we should be reimbursed for our work.

Recommendation: add verbiage to (2) above as follows "… provided the information was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing a comprehensive medical-legal report or a follow-up medical-legal report; This would align with the definition under 9793 (m) for supplemental report.

- I have the same issue with the "Remedial supplemental report"

Consider revising as follows:

Remedial Supplemental Medical-Legal Evaluations. This code is designed for communication purposes only. It indicates and acknowledges that compensation is not owed for this report. This code shall be used for supplemental reports (1) addressing an issue that was requested by a party to the action to be addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation, or (3) addressing an issue that should have been addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation pursuant to the requirements for a medical-legal evaluation and or report as required by any provision of title eight, California Code of Regulations, sections 9793, 9794 and 9795. *provided the information was available in the physician's office for review or was included in the document record provided to the physician prior to preparing a comprehensive medical-legal report or a follow-up medical-legal report*

The physician should not be paid extra for doing sloppy work. So, if all the necessary information for the physician to address the issues presented has been received TIMELY, then, the physician should issue a thorough report addressing the issues presented by the parties. Let's say, I am asked to address work status and I failed to do so. I should not be paid for a supplemental report when the parties send me a letter saying, hey, doc, what's the work status?

On the other hand, if the applicant tells me there were x-rays done, I will request the images of the studies to address impairment/apportionment. I later get a letter telling me the x-rays cannot be obtained or I get the images and they did not take views I need,

etc., I then have to order xrays to issue my opinion and will have to issue a supplemental report even though I was asked at the very beginning to address impairment rating and apportionment. That supplemental report should be reimbursable as I will spend 2 maybe 3 hours reading the images, preparing the impairment rating, formulating my opinions and dictating my report. I trust you will agree this is not "remedial" work.

- The timeliness of the information received should be reference by code, CCR 35 (i) in the Definition section (m) or under Authority.

I believe if you revise the verbiage concerning supplemental reports you will prevent billing disputes.

- Consider changing the effective date of the Med-Legal Fee Schedule to October 1, 2020.

We all know this revision is long overdue and we should not have to wait another six months to be adequately compensated.

Thank you for your consideration.

Karen Montalbano, D.C. June 26, 2020

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Sarvanan Ram June 26, 2020

The new proposed medical legal fee schedule is positive and in the right direction and will ensure retention of highly qualified experts to provide this invaluable service and serve the needs of the injured workers, attorneys and the Division of Workers' Compesation.

Dr. Tim Walth June 26, 2020

Should you take all the meat out of the reimbursement for evals and all of the associated reimbursable expenses you will be left with vermin picking at scraps. The quality of the evals will become diminished.

Reasonable adjustments can help but without taking into consideration of the costs of practicing and living in this state and make allowance for that as well as COLA adjustment is unreasonable.

Angelica K.C. Acton L.Ac., QME June 26, 2020

As a QME of 4 years, I know how important the QME is for the workers compensation system and for injured workers. It is a shame to see the state of California and the DWC does not see this.

As we all know the process of performing exams and writing reports is already a tedious process. By decreasing the pay for QME's, you are at risk of losing them. My specialty of Acupuncture already has very low numbers. The pay decrease will not help this matter.

Please reconsider the payment changes for QME compensation.

Raphael Morris, M.D. June 26, 2020

I currently have a large clinical practice in San Diego, treating all sorts of patients, including injured workers, who have for many years been a terribly underserved population that are chronically trapped in a chaotic treatment setting due to the top priority being cost savings.

I have continued to serve this population with chronic pain and treatment resistant mood disorders with medications, psychotherapy, and more recently with Transcranial Magnetic Stimulation. I have also been conducting criminal forensic psychiatric consultations around the country for the past 19 years and after moving to California around 13 years ago, I became a QME.

Although I accepted the challenges inherent in producing quality evaluations based on the limits of having to rely on the records produced by the carriers, I considered that my fellow QME’s and I were carrying out the important function of attempting to make sense of these cases and sort out the issues for the applicants and the attorneys involved.

Regarding reimbursement, I have yet to meet a fellow QME who was satisfied with the fee schedule, particularly because conducting QME’s requires you not only accept an hourly fee that is below that which you would earn doing clinical work and because accepting QME work necessitates that you pay a skilled support staff to organize the cases, send out mailings, and field all the calls that accompany every report and every request for supplemental reports. I rationalized that the trade off was being able to charge for the time required to produce the reports.

For many years, this $250 per hour rate has been much lower than most physicians can earn in private practice seeing patients and the only saving grace for QME work was

that the record reviews and report writing could be done at your convenience in a home office. In addition, clinical work requires much less clerical support.

I never complained that the fees for depositions never increased in all these years despite the fact that most physicians can command $400-800/hour for depositions.

I could spend hours complaining about the following:

- The extreme waste of resources spent on 3rd party reviewers for treatment cases and how the medical reviewers are not provided the entire file before they deny medically critical treatments that force responsible physicians to waste their time writing up appeal letters that get lost.
- The way adjusters are switched on cases without ever telling the treating physicians, who only find out when treatment is delayed and efforts are made to contact the adjuster but to no avail. Can you imagine if a physician left his or her caseload without informing the relevant parties?
- The number of times I had not received a call back from a carrier when all I needed was clarification of a letter has been maddening.

When I read your proposal for a flat fee for psychiatric QME reports of around 3K and supplemental reports for much less and having to count the number of pages I review, I was ready to weep. Where is the appreciation and respect for the experts who are already underpaid and willing to evaluate these extremely complex situations?

In looking over my cases, I would say that my fees have ranged from 2.5K to 7K with the majority of cases ranging between 3.5 and 5K per evaluation. If you lower the reimbursement to 3K, I may have to consider passing on future referrals. Only a case with scant records can be conducted in less than 12 hours at $250/hour. Many of my colleagues have already quit doing QME's because the reimbursement is already too low.

As all medical legal reports are subject to possible subpoenas and depositions, it is in the back of my mind that my report can become part of a public record. I can't be asked to rush to form a medical-legal opinion that if unsubstantiated, could be referred to in a future trial by a cross examining attorney. I have to be able to arrive at an opinion that is substantiated by a careful review of documents related to the case (which are often incomplete at the time of the evaluation).

The proposed cuts in essence will create the following reality:

In order to provide a responsible opinion with adequate medical evidence, The DWC is asking experts to work pro bono by spending multiple unreimbursed hours reviewing records in order to avoid arriving at incorrect opinions.

In my experience, the average psychiatric QME takes between 15 and 25 hours to produce, depending on how far back the injury goes and how many records must be reviewed.

Only very few will require more than 30 hours and almost none will take less than 12 hours.

These evaluations affect the lives of the injured workers and in my humble opinion, it is poor judgment to encourage experts to do less work than is reasonably indicated.

Can you imagine any self respecting forensic psychiatrist hired on a murder case being told they had to do the evaluation for a embarrassingly low flat fee. It doesn't make sense and it's inappropriate.

Don't we want to attract the best and brightest to do QME's. A recent graduate of an East Coast forensic psychiatry fellowship program just asked me several weeks ago about doing QME's in California as she is planning to move here and now I don't know if I can recommend doing them under these constraints.

I rarely charge for research but if the case is complicated, then some research should be conducted.

As for counting pages, it's not the number of pages that matter but how long it took to carefully review those records. Are we going to penalize an expert because the records were more dense and reward one who had 10 times the number of pages but most were billing records or medication logs. Does that make sense? Does it even make sense to ask a physician to spend time counting pages?

Are we trying to dumb down our evaluations?

I am all for ensuring that billing is reasonable but there has to be a better way to save money than to reduce reimbursement for the experts who are in my experience are already losing interest in doing these cases.

Judith A. Thurber, DC, QME June 26, 2020

The proposed changes to the QME Fee schedule are totally unacceptable. If you adopt this new fee schedule YOU ARE FORCING ME TO STOP DOING QMEs after 30 years.

I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, **general reimbursement**

levels and terms were agreed upon. It is APPALLING and discouraging that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

It is becoming quite clear to me that the DWC is not interested, in the slightest, in protecting the injured worker's rights and providing the injured worker with a competent and knowledge QME physician.

Although you are proposing to increase the rate for the initial evaluation, you limit the rate on the follow-ups and supplemental reports, You have disregarded if there is a complex history to take, requiring more time, multiple injured areas, multiple injuries over time and if medical research IS REQUIRED.

In my practice the initial evaluation is usually a Basic QME, because the carrier hasn't sent any records, the patient isn't P&S etc. It's the follow-ups and supplemental reports that are very time intensive.

Everything under the new fee schedule is under a flat fee. This is TOTALLY UNREASONABLE. Injured workers present with many varied issues. With Complexity factors and hourly rates I can do what is necessary for each case with reasonable reimbursement. In the last 3 QMEs I've done each one has required 2-4 hours of medical research to explain to all the parties the complexity of the worker's condition. One of them required a supplemental report on about 800 pages of records. I AM NOT WILLING TO DO THIS FOR FREE.

While you have adopted the ***structure*** of the Nevada state IME fee schedule, You inexplicably continue to propose much lower ***fees*** than those found in the Nevada schedule. Additionally, you wants me to review 200 pages before I get compensated for any record review. Nevada thinks 50 pages is more reasonable. Why would I want to spend about 2 hours of my time on records? I AM NOT WILLING TO REVIEW RECORDS FOR FREE.

Under the current proposal, if I get a lengthy set of records to review, then I can only bill $2/page after the first 1,000 pages. Today, on average I bill $2.50/page (assuming $250/hr and 100 pages reviewed per hour). So you want to slash my reimbursement by 20% from $2.50 to $2.00 per page. So then I "get to" bill at 1996 rates in 2020 in Northern California. **And to top it off YOU WANT ME TO COUNT THE PAGES, so I have the opportunity to fight with the carrier about how many pages I reviewed to get paid.** This is TOTALLY UNREASONABLE.

And you still have not included a cost of living increase. Is that how your reimbursement for your works for your performance at work?

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was I endorsed and was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

Sue Honor's proposal and the accompanying petition can be found here: https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is demoralizing. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California. If you adopt this Fee schedule ***I CAN NOT AFFORD*** to perform QMEs any longer.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement, deal with the carriers delays or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues. I believe that the injured worker deserves a knowledgeable Doctor to determine their case. This proposal will destroy that.

This proposal will be the final straw for many providers, including myself. Again, if you adopt this proposal YOU ARE FORCING ME TO STOP DOING QMEs after 30 years and harming the injured worker.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

I truly hope that you change your mind and **PROTECT the injured worker's rights.**

Gregg M. Baringoldz, Ph.D., Q.M.E. June 26, 2020

I have reviewed the proposed changes regarding compensation for medical/legal evaluations, and find them unacceptable. I understand that DWC hosted stakeholder meetings between insurance payers and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these agreed upon levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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Sharon Goldstein, Ph.D. June 26, 2020

I have been performing psychological evaluations in the Workers' Compensation system for thirty years. I have been a QME from the beginning of this requirement.

I am greatly concerned about the rate changes put forth by the council. If they go through as proposed, I anticipate the degradation in the quality of evaluators and the psychological evaluations. This will only lead to a poorer outcome for the injured workers themselves, though not the insurance companies.

Speaking for myself, I do not know if I will continue to work as a PQME beyond the renewal I just sent in.

I strongly encourage the council to re-evaluate their decision.
Thank you for your consideration in the matter.

Anonymous June 26, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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Adam G. Brooks June 26, 2020

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This proposal will be the final straw for many providers, including myself.

As a physician who both diligently and efficiently completes QME reports in a timely manner, and a physician who relies on QME reports to help facilitate future treatment

for my patients, I am extremely disappointed and frankly scared of what the consequences of such a change will cause.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

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William G. Moseley, M.D. June 26, 2020

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I am one of 2 remaining Urology QMEs in San Diego and will quit being a CA QME in Urology. I you enact this proposal and it becomes law, I will quit being a Urology QME. Your proposal is totally unfair and not worth my time being a QME.

Michael Carlish, Ph.D. June 26, 2020

I am a psychologist and have been a QME since 2016. I have valued the opportunity to work in this field and hope to continue as a QME for many years - I see applicants at 10 locations and I would use more locations and do more evaluations if this were available to me.

The proposed fee changes would force me to limit my QME practice, however. I am deeply concerned that this fee structure would decrease my compensation to the point that acting as a QME would no longer be cost effective. A lot is asked of doctors in these cases and my reports, and the reports of colleagues which I have reviewed, are quite comprehensive. It takes a lot of time to produce these reports - which face scrutiny from all parties - and I think it's fair that doctors be compensated accordingly.

I hope the DWC will reconsider this proposed fee schedule, both for QME's such as myself and for the injured workers who rely on experienced and professional doctors to move their cases along.

Michael G. Bloom, M.D. June 26, 2020

I as others as internists do an extensive amount of work evaluating work comp patients in a fair objective manner. The present fee schedule is adequate but the new proposed one is not worth my tireless effort in providing an excellent evaluation of the many complex issues involved in a case. Please consider not making any changes to the present fee schedule.

Theresa Phillips PsyD., QME June 26, 2020
Clinical Psychologist

I am writing to address the proposed changes to the QME payment schedule comparing our rates to the state of Nevada.

As a psychologist, we are required to obtain a license, work for five years without infraction, take a course, take an exam which can take six to seven years post licensure.

With all due respect, this may pose a problem in having well qualified examiners. Many will choose to follow a different path. Since the outbreak of the Coved 19 virus and subsequent shelter in place, many are choosing not to go back to this type of work.

AND THERE IS A BACKLOG OF EVALUATIONS TO ADDRESS. NOT TO MENTION ADDITIONAL CLAIMS DUE TO THE CORONA VIRUS.

THE CLAIMANTS WHO DESPERATELY NEED ASSISTANCE WILL BEAR THE COST OF THIS PROPOSAL AS WELL.

QME's have not have a raise in payment in over four years and now you are asking us to work for less?

Office expenses and support staff costs have increased and now you are asking to have it cut into our pockets.

These stressful times have created an unprecedented need for therapy and now tele therapy is an option for examiners to work from home and seek other employment sources.

I would like to see a per diem amount for remote locations to be addressed as well.

Thank you for your time and consideration.

Feel free to contact me if you require further assistance or have any questions or concerns.

Rachyll Dempsey, PsyD, QME, ABPP June 26, 2020

I am writing this in response to the most recent proposal for a flat rate fee for qualified medical evaluator assessments and reports. I can only speak for psychologist, but it does not make sense to have a flat rate because this will encourage shortcuting which in turn Defeats the purpose of having an expert evaluate an individual.

For some reports, testing with an individual is quite extensive and may require six+ hours (plus scoring and interpretation), for others there's only a couple of hours of testing. For those that require a lot more testing, with this new proposal, I can see a lot of experts reducing the amount of very much needed diagnostic testing Due to the lack of compensation. In essence, a flat rate structure will result in poorer quality, less informed answers to the Trier of Fact, and injured workers not receiving the expertise needed.

Further, it will encourage people to leave the practice therefore reducing the amount of experts on the panel.

I urge a reconsideration of this bill

Baba Singh, Psy.D., QME June 26, 2020

I have reviewed the current proposed changes to the QME fee schedule, and I am extremely disappointed at this 'stealth' effort to cut QMEs out of the conversation, to agree to listen to us then just do what was planned anyway. I think it's in bad faith, and it's an insult to the work we do for the state. I do hones work as a QME – it's not my primary income, it's a service to injured workers in the service of California. I take pride in it, that I can do some part time work as a public service. I do good work for California, and this latest proposal is a slap in the face. Please find a more reasonable fee schedule that includes the interests of all parties involved in QME work.

Delia M. Silva,Psy.D, ABPP-CN, QME June 26, 2020
Board-Certified in Clinical Neuropsychology

I am a board-certified neuropsychologist and QME in San Diego, who continues to do psychological QMEs, even after the DWC eliminated neuropsychology as a subspecialty. The current proposals to change the QME fee schedule is an additional slap in the face and may be the last straw for me in continuing to do QMEs if it passes. I am cutting and pasting the following email that I am sure you have received from others, which details the concerns QMEs have with the proposed changes.

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting,

AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

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This proposal will be the final straw for many providers, including myself.
I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

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Mark Shabason June 26, 2020

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Anne C. Welty, MD June 26, 2020

QME Psychiatry

The proposed QME fee schedule will definitely ensure that quality examinations from experienced QME's will continue to decline and disappear. The current fee schedule is low enough, and with additional cost of office rental, dictation costs, and staff expenses, does not adequately reimburse current QME's.

There have been several more reasonable fee schedule proposals. I urge your consideration in order to give injured workers the quality examinations they deserve.

Linett Mace June 26, 2020
Coastal Medical Evaluations & Billing

After long review, I find the proposed changes to be unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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I find it very disheartening in the fact that you have disregarded essentially all of Sue Honor's qualitative suggestions. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers.

This proposal will be the final straw for many providers, and what degree of professionals will be left to handle future QME casework.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

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William W. Deardorff, Ph.D, ABPP, QME June 26, 2020
I can understand the need for cost-containment measures, but the proposed changes will have significant unintended consequences. As a psychologist, I am an expert in

human behavior and reinforcement principles. If you implement these changes, you will be reinforcing some behaviors and punishing others. Unfortunately, the behaviors you will be reinforcing will not be good for the WC system and the behaviors you will be punishing will cause high-quality QME doctors to stop doing QME work.

If you implement these changes, the result will be poor quality, highly templated evaluations and reports, (done by doctors accustomed to operating on a lien basis), that do not validly address the issues in dispute.

Given the significant drop in reimbursement, you will also see a mass exodus of quality doctors from the QME panel system. These doctors will be replaced by those with minimal experience and will to operate on a lien basis.

If these changes are implemented I simply could not afford to complete a high- quality evaluation and report. I cannot speak for other disciplines, but for psychology, the evaluation process is extremely labor and time-intensive. This complicated process is inherent in addressing all issues in dispute but primarily causation, apportionment, and impairment.

If these changes are implemented, and the likely reimbursement decrease follows, I would likely stop doing QME evaluations. I will address some of the consequences of these proposed changes in the following:

If prior agreement of the parties is required under any provision of this regulation, the physician may not condition performance of the evaluation on receipt of prior agreement of the parties.

I have had many cases in which applicant's attorney (AA) have set up a QME evaluation either without the agreement from Defense or despite objections by the Defense. In these cases, I do not complete the QME until I get prior agreement from the parties since I do not take liens and never have. If I do not have agreement from both parties regarding the QME, I will not schedule it. Under the above, AA could set up any QME desired. The only consequence is that the QME is forced to do the evaluation and put it on a lien. The AA request for QME evaluations will likely increase significantly since they have nothing to lose. They are not out the time and effort it takes to do a QME evaluation that has to be put on a lien. You will see QME doctors who do not take liens leave the panel system.

Secondly, if this provision is passed, why would the Defense provide prior agreement to ANY evaluation? Why not allow it to proceed on a lien and fight the costs later? At the very least, the Defense would begin to be very, very conservative in agreeing to any QME unless forced to do so (since the QME would be forced to proceed without Defense agreement).

If this condition is passed you will get a group of QME doctors that are willing to do a lien QME practice and all the other reputable ones will quit. The AA's will use these doctors through the panel process and the rate of QME requests (under these conditions) will increase dramatically (likely all poor quality). If this provision means that I would have to do QME evaluations that are not approved (e.g. go to a lien), I would stop doing QME work. This provision will result in a lien-driven, low quality, AA oriented, QME process.

A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the start of the evaluation, that the evaluation involves extraordinary circumstances.

For psychology/psychiatry, this provision will often be at odds with the one cited previously. Psychology QMEs are inherently complicated and usually required an ML104 evaluation. However, the previous provision says we cannot require agreement by the parties before completing the evaluation. So, I would most likely be doing ML104 evaluations but I cannot require the parties to agree on the evaluation. This means that I would be forced to do ML104 evaluations on a lien basis which I will not do. I would quit the QME system.

Another consequence of this provision for psychology is that the Defense would begin to only authorized ML103 and lower (there would be no reason for them not to). The vast majority of the QME and AMEs that I complete are at ML104 due to their complexity. If I cannot complete the evaluations in a valid and ethical manner, I would stop doing them. I cannot do most of my QMEs at ML103 or lower.

For ML104, four or more complexity items are required and "The report must include all information required to claim each complexity factor relied upon, and no more than three hours may be billed for report preparation."

I understand the goal to contain costs, but this provision would make doing a proper Psychology QME impossible. The cases I evaluate are extremely complicated and time-consuming. My reports are typically between 40 and 100 pages simply due to the number of issues that must be addressed and the amount of material involved. Report preparation includes the time to formulate the conclusions, the time to dictate, transcription, editing the final product, etc., etc. If I do a QME evaluation on a Monday, the following 4 to 5 days are necessary to complete all aspects of the report (maybe 15 to 35 hours of report preparation time. I address all issues completed. As such, I have never had the charges disputed by an insurance and I have only been deposed once in the last 6 years about something that was not clear in a report. I truly put in the time documented in the report and it is all necessary.

If I was limited to 3 hours of report preparation time, it would impossible to do a high-quality report. If this is implemented, you are going to get very highly templated reports that largely all reach the same conclusion for every patient (since there would be no time to individualize the report). You are going to see a very significant drop in the quality of reports. This will be for two reasons: All of the doctors who can do high quality reports will no longer be in the QME system (like me) and doctors who stay will give you just 3 hours of report preparation time (you get what you pay for). These will be all templated and not individualized.

For ML106 - No more than three hours may be billed for report preparation under this code. No more than two hours may be billed for medical research under this code. In order to bill for medical research under this code, the physician must use sources that have not been cited in any prior medical report authored by the physician in the preceding 12 months in support of a claim citing or relying upon medical research in billing. An evaluator who bills for medical research under this code must also (A) explain in the body of the report why the research was reasonably necessary to reach a conclusion about a disputed medical issue, (B) provide a list of citations to the sources reviewed, and (C) excerpt or include copies of medical evidence relied upon.

The 3-hour report restriction is a problem here for reasons cited above. In addition, what about the case in which a patient is seen but the QME wants more information in order to address all issues in dispute. The new information comes in (e.g. 500 pages of medical records), and the supplemental report then addresses everything. For that report only 3-hours of preparation would be allowed. Imagine the quality of the report you will get if a doctor only spends 3 hours preparing it (including dictation, transcription, editing, copy, and sending).

Another issue here is arbitrarily limiting the medical research to 2 hours. I rarely go over 1.5 hours for medical legal research but I have on occasion especially when the parties ask for conclusions about a complicated subject (e.g. whether or not a fainting episode was conversion, pseudo-seizures, work-related, etc.). Again, if you limit it to 2 hours then that is what you will get. QME doctors will research for 2 hours and, if the question is not answered, they will “wing it”.

I can understand wanting to have the QME include the copies of the medical evidence (beyond citations) but you are going to end up with massive reports. If I included the actual articles that some of my reports cite, the page count could easily go to 200-300 pages while not adding anything substantive to the report.

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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Cheri Adrian, Ph.D., QME June 25, 2020
Cheri Adrian, Ph.D. Psychological Services, PC

The proposed changes to the QME compensation schedule are absolutely unacceptable. DWC hosted stakeholder meetings between insurance payors and QMEs

over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings! You are not serving the interests of workers, at all. Workers need competent evaluations. You won't get them this way.

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It is impossible to function as a QME in California with this fee schedule, ESPECIALLY for mental health issues Many of my colleagues have quit serving as a QME. Most quality psycholgoists have avoided becoming a QME because they cannot survive on the current schedule let alone what this proposal would mean for an hourly wage. The free time required for reviewing 200 pages of records! is especially insulting and ridiculous. No one can review psych records in the time that would be required under this fee schedule.

You propose a fee schedule making it impossible for a QME in psych especially to do a competent report sufficiently based in data and argument; and then you will discipline QMEs for not making a sufficient argument with regard to their conclusions. We lose on both ends. Who will work under these conditions?

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Kevin Deitel June 25, 2020

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Michael Fischman, MD, QME June 25, 2020

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I am only one of a few QME physicians in the category of occupational medicine/toxicology. My evaluations typically involve medical research regarding the toxicology of the involved chemicals. I cannot continue to do quality QME evaluations if I am unable to bill for the time required to do necessary medical/toxicology research. Because of the administrative burden and the poor present reimbursement, I have considered abandoning my role as a QME (something I have done since the inception of the QME program many years ago). I will have to reconsider participation if the current proposed changes go into effect.

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Stephen Dell, M.D. June 25, 2020

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Shaul M. Saddick, Ph.D., QME June 25, 2020
Clinical & Forensic Psychology
Clinical & Forensic Neuropsychology

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Stephen M. Pfeiffer, Ph.D., QME June 25, 2020
Fellow – America Psychological Association
2015 California Psychological Association – President

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Elliot Gross MD June 25, 2020

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Alec Koo, MD, Urology QME June 25, 2020

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James Deck, Ph.D., QME June 25, 2020

This is a joke, proposed strictly by insurance carriers for financial gain, at the direct expense of applicants.

Vladimir Lipovetsky, MD, FIPA June 25, 2020

I have been a psychiatry QME for 10 years. Over the last few years the DWC has consistently attempted to reduce the level of compensation for medical legal reports, whether it is under the abusive assumption the all QMEs are engaged in fraudulent activity or for other reasons never disclosed to the public or the QMEs. I have been repeatedly complemented on the thoroughness of my reports by attorney's on both sides during the depositions and I take pride in carefully preparing the reports. As a

psychiatrist, I see the claimant for 2-3 hours face to face to take “the usual careful history” that the advocacy letter asks for. Between the integration of interview and medical record material, dictation and editing (without including the record review) the process takes me a total of 12-13 hours. If you include 200 pages of review, it will take and additional 2-3 hours on average.

So for 15 hours you are proposing I should be compensated $3000, or $200 per hour, or 20% reduction in pay. Now I am supposed to believe that the great honor of participating in the illustrious Workers’ Compensation system is worth taking that paycut when online clinical work pays $250-350/hour, private practice pays $400-500/hour and forensic work in the state of California pays $300-350 per hour? Really? And this is happening after the Auditors report that brings up as has been brought up over and over again that the fees never went up after 2006? Are there any DWC employees of who this could be said, that their salaries stayed the same since 2006? If this proposal is implemented or if some gimmick is added as a “correction” without respectful payment for the work that you have been appointed to oversee, I and people like me, who aim to produce quality reports, will leave the field, which is likely what is wanted. Perhaps DWC would be happy to appoint nurse practitioners, chiropractors and MFTs to do the same work for minimum wage or generously double it.

You obviously intend to drive the present system into the ground and I am sure someone will be paid handsomely for it. The injured workers will be less than thankful for the disappearance of neutral opinion. Perhaps the applicant attorneys could consider tort suits against employers due to the failure of the great compromise. When the whole thing falls apart and employers are in an uproar over their increased liabilities, I am sure you all will move on to other government positions and deny all responsibility.

Dr. George Joseph Grosso June 25, 2020

Inadequate reimbursement is leading me to conclude that after 25 years as a QME that it is no longer financially feasible and time to move on to reasonably reimbursed work.

Kevin Li, MD, QME June 25, 2020

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Stuart Fischer, M.D., F.A.C.P, F.A.C.C. June 25, 2020

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Elizabeth Preston Cisneros, Ph.D.
Clinical Neuropsychologist
Qualified Medical Evaluator

June 25, 2020

I am reading with absolute horror the new proposed changes to the QME med-legal fee schedule. I thought these issues had already been addressed in stakeholder meetings, but it appears that DWC is going back on those agreements.

I have been a QME for five years and am one of the few QMEs who is a practicing clinical psychologist and neuropsychologist in my area - most others just do QME evals at multiple clinics and crank them out. I take great pride in providing injured workers and workers compensation case managers with a fair evaluation that is in keeping with what I provide my cash pay or Medicare clients. Psychological evaluations are extraordinarily

complex. Our interviews are far longer, our testing is far longer, and our reports are far more comprehensive than other QME disciplines. That's why it has been recognized as a complexity factor.

Under the current proposed changes to the fee schedule, I would be getting paid significantly less per hour of my time for a complex med-legal psychological evaluation than I do for a basic Medicare evaluation. The flat fee schedule encourages QMEs to perform the most basic of evaluations, rather than really evaluating the issues to the extent that is needed to treat both workers and workers comp companies fairly. It will also put much more of the onus on the QME to do the work that should fall on the workers compensation insurance company or case manager - keeping up with pages of medical records, for example. It also provides so many opportunities for insurance companies to try to cheat QMEs out of payment that they are rightly owed - through requests for supplemental reports that they think "should" have had things addressed initially, for example. As a QME, our rates have already not increased in 14 years. It is clear that DWC does not respect the QME or the level of detail and intensity that these evaluations require to do an ethical job. Why would DWC propose to pay us less than what we have been making in the last 14 for more work.and to make it harder to be paid for what we are rightly owed? I routinely have to fight for a year just to get paid for a QME exam that I have done in good faith, when the insurance company just doesn't want to pay their bills. These proposed changes will make those instances increase exponentially.

If these changes go through, I will no longer perform QMEs. I will not be party to a system that will pay me less than what Nevada is paying their similar experts and for a fee that is less than Medicare rates per hour. You will be left with a shoddy system that only has doctors who spend almost no time with the patient and just submits boilerplate reports so they can see as many patients as possible to maximize their reimbursement under this new fee schedule. This proposed fee schedule makes it very clear that DWC is favoring insurance companies over injured workers and medical professionals who have devoted their lives to providing high quality medical care to patients.

Dr. Sanjay Agarwal June 25, 2020

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Dr. Zachary D. Torry June 25, 2020
Adult and Forensic Psychiatrist

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Troung P. Nguyen, DC, QME June 25, 2020

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The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

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Dr. Anthony Fenison June 25, 2020

Great job!! I know it was difficult and it's impossible to please everyone but I think what the DWC did was fair.

Hose Kim, M.D. June 25, 2020

Orthopedic Surgery

I have several concerns about the new proposed MLFS:

- For initial M-L 201: I am alright with a flat free as long as the 200 page record review is not included. First of all, it takes much time and effort to review 200 pages of medical, especially orthopedic records. The proposed fee schedule, in my opinion, would not result in that much of an increase as compared to the

current fee schedule. Secondly, the insurance company will likely try to keep the records under 200 pages, which will likely result in cherry-picking records, thus frequently leaving out critical pieces of records. This will obviously result in substandard PQME reports, which doesn't really help anyone, certainly not the injured worker. I strongly propose a flat fee system, ***not including*** the 200 page record review requirement.

- $3 per page of record review is too low. In Nevada, they are paying *more than* $5.50 per page. The cost of living and doing business/practice in California are higher (certainly not lower) than they are in Nevada. So, why such a big discount?!?
- My biggest concern is in regard to ML-202 *and* -203 for a similar reason. As everyone knows, on more instances than not, re-evaluation and supplemental report requests come in many months or often more than a year after the initial evaluation. There may be new records (up to 200 pages record review included as initial, which again I am against) sometimes not. But what about the pre-existing old records, which need to be reviewed again to adequately answer and address the questions posed to the PQME? There appears to be no provision for that. In that case, the PQME will not be reviewing the pre-existing records, which often include his own deposition transcript, because that takes much time and effort. Hence, the quality of the report would certainly suffer if the evaluator does not re-familiarize himself with the pre-existing records as they relate to the new ones. This issue needs to be addressed.

I am sure there are other issues I may have overlooked, but these are the main ones. Thank you for reading.

Dr. Keri Jones June 25, 2020
Clinical Psycologist
Qualified Medical Examiner

I just reviewed the medical legal fee schedule for psychiatrists/psychologists-the initial evaluations and re-evaluations.

Boy, talk about a rate cut and a slash in holding mental health in parity with other injuries and illnesses. This is hard to take. Are we in 2020?

I would ask that you reconsider this RATE CUT and contemplate how complex mental health evaluations are, and the time it takes to review records, and to provide thorough analyses of the cases set before us.
Really.

Cliff Straehley III June 25, 2020
QME Psychiastrist

Psychiatric cases usually require various psychological test which are not free for the physician. I did not see an explanation of payment for the costs of those tests

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Claude S. Munday, Ph.D June 25, 2020
Psychologist

There is a math issue that requires your attention.

If we have a psych evaluation the basic fee is $2015 x 1.6 or $3224. I would think if the eval is an AME that we should then apply the AME modifier of 1.35 which gives us 4352.40.

However, you are proposing a 1.85 modifier for a psych AME. This results in a fee of $3727.75. Essentially a psych eval is not getting the full benefit of the AME modifier.

Please reconsider.

Cliff Straehley III June 25, 2020
Psychiatrist QME

When preparing both supplemental reports and additional reports concerning additional "face to face" evaluation reports, it is necessary to review and briefly summarize all prior reports including especially the initial evaluation report. Just paying for reviewing the number of pages of new records does not pay for the time spent reviewing prior reports. Those reviews are necessary in order to prepare an accurate and useful subsequent report. Commonly, subsequent reports are requested years after the earlier reports and it is not possible to remember important details of the earlier reports without reviewing them. The time spent on those needed reviews should be paid for. Not doing those reviews would decrease the accuracy and value of subsequent reports.